FROM POLICY TO PRAXIS: RETHINKING COMPREHENSIVE INTEGRATED PRIMARY MENTAL HEALTH CARE

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ABSTRACT

In this dissertation I have provided an academic interrogation of the gap between policy principles for comprehensive integrated primary mental health care in South Africa, and the implementation thereof.

I argue, theoretically, that the current add-on approach, which emphasizes care for patients with serious mental illness, will not achieve the vision for comprehensive integrated primary mental health care in South Africa. I suggest that this trajectory is a product of the reformist approach to the implementation of primary health care, and suggest that what is needed is a shift towards a comprehensive discourse of care at the primary level.

My research aimed at developing an understanding of how such a shift could be achieved. It comprised two phases. In the first phase, I developed, implemented and evaluated a reorientation programme for primary health care nurses in an identified sub-district. I adopted quantitative research to assess the efficacy of the programme, and qualitative ethnographic inquiry to develop an understanding of the factors mediating the capacity of the nurse participants to provide comprehensive care. The Tavistock model of organizational change formed the overarching theoretical framework for the analysis of my emergent data.

My findings from this first phase highlighted, inter alia, the mediating role played by the organization and structure of the health care system in inhibiting the capacity of the nurse participants to provide comprehensive care. The second phase of my research thus involved developing an understanding of the issues that would be involved in transforming the health care system to one which would be supportive of a comprehensive discourse of care.

A key finding was that the health care system functions as a social defence system, structured to defend against anxieties generated by comprehensive care. A dynamic appears to operate whereby, through the process of schizoid splitting, primary health care, which is associated with the anxiety provoking psychosocial aspects of ill health, is attributed an 'underdog status'. This serves to promote the idealization of specialist biomedical care. Furthermore, it services a broader agenda of self interest through promoting the hegemony of biomedical ideology which is inextricably linked with the capitalist global economy.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
APA	American Psychological Association
DALY	Disability Adjusted Life Year
DOSMD	Determinants of Outcome of Severe Mental Disorders
DSM IV	Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition
CMHP	Community Mental Health Programme
GEAR	Growth Employment and Redistribution
HIV	Human Immunodeficiency Virus
IPSS	International Pilot Study on Schizophrenia
NAMDA	National Medical and Dental Association
NICHE	Natal Institute of Community Health Education
NIMHANS	National Institute of Mental Health and Neuro Sciences
OASSSA	Organization for Appropriate Social Services
PHC	Primary health care
RDP	Reconstruction and Development Association
STD	Sexually transmitted diseases
TB	Tuberculosis
WHO	World Health Organization

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CHAPTER 1

AN INTRODUCTION

1.1 Introduction

This thesis is concerned with interrogating the gap between policy principles underpinning the transformation of the mental health care system in South Africa, and the implementation of this transformation. My key contention is that while a shift from a vertical, largely institutionally based mental health care system to *comprehensive* integrated primary mental health care is central to these policy principles, it is not being implemented. While South Africa has been engaged in a flurry of policy formulation over the past decade, policy makers generally do not have the luxury to engage in in-depth analysis of the feasibility of their policy formulations. As Pillay (1999) suggests, researchers have a critical role to play in ensuring the implementation of policies for the betterment of society. In light of this, I offer in this thesis, an academic interrogation of the gap between policy and praxis with regard to comprehensive integrated primary mental health care in South Africa.

My interest in this area of research emerged from my work as coordinator (1994 - 1997) of the Community Mental Health Programme (CMHP), an outreach programme attached to the Psychology Department at the University of Durban-Westville, where I am employed as a lecturer. During my period of office as coordinator, the CMHP was engaged, inter alia, in the development of a district-based mental health care system in the KwaDedangendlale area of the Outer-west District of the Durban Functional Region. Durban is a city located on the eastern seaboard of South Africa, and KwaDedangendlale is a semi-rural area, approximately forty kilometres inland from the city of Durban (see Figure 1, p. 3). Funding support for this initiative was received from the Trust for Health Systems Planning and

Development in South Africa as well as the Independent Development Trust of South Africa.

Following a situational analysis, which included a community-based epidemiological study of mental illness, a two pronged approach to the development of a district-based mental health care system was adopted. One prong involved the reorientation and training of primary health care personnel within the system to provide comprehensive care. This included the identification and management of mental health problems, as well as the implementation of a referral and information system to ensure continuity of care. The second prong involved the development and implementation of primary and tertiary prevention programmes using local resources, such as community health workers, for specific mental health problems which were considered a priority by the community. A number of publications and reports have emerged from these efforts at developing a district mental health care system (e.g., Bhana & Wilford, 1996; Bhagwanjee, Parekh, Paruk, Petersen & Subedar, 1998; De la Rey & Parekh, 1996; Memela, 1997; Parekh & De la Rey, 1997; Petersen, 1997; Petersen, 1998; Petersen, 1999; Petersen, Bhagwanjee & Parekh, in press; Petersen, Bhagwanjee, Parekh, Paruk & Subedar, 1996; Petersen & Pillay, 1997; Sawyer, Ngwenya, Memela, Petersen, Subedar & Parekh, 1996).

While the community-based prevention projects were relatively successful, the reorientation and training of primary health care personnel proved to be more difficult, with resistance being experienced from both primary health care personnel and psychiatric personnel. Given that the transformation of the mental health care system in South Africa hinges on the successful integration of mental health care into primary health care, the need to develop an in-depth understanding of the factors impeding this process therefore formed the basic motivation for the study reported on in this thesis.

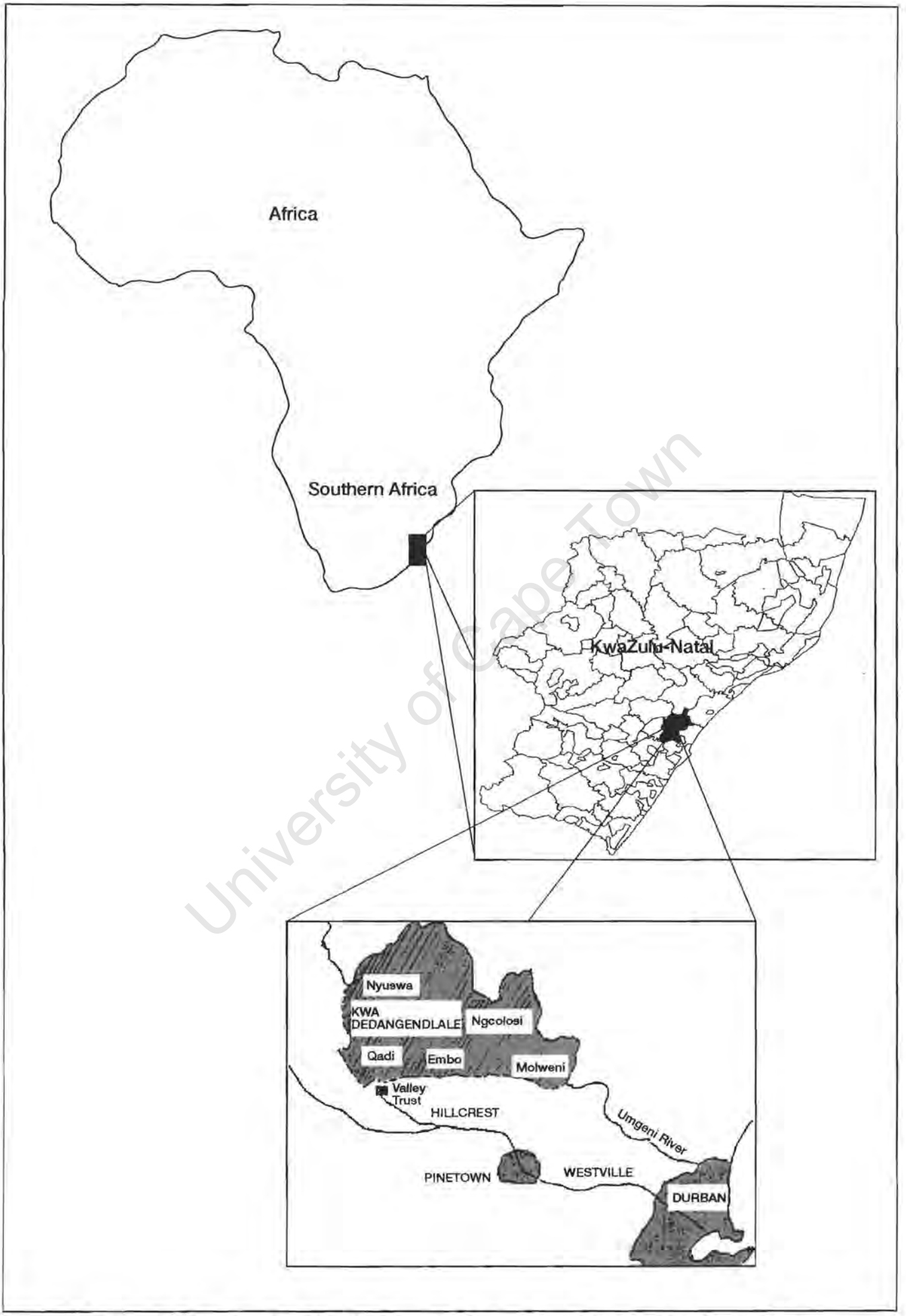

Figure 1: Map showing KwaDedangendlale area in relation to Southern Africa

1.2 An outline

This thesis comprises two sections. The first section provides a contextual and a conceptual chapter which together lay the foundation for the research study, which is reported on in Section Two.

Chapter Two, a contextual chapter, locates the transformation of the mental health care system in South Africa within the shift towards primary health care in low-income countries generally, and within South Africa specifically. It provides the historical background to this shift and analyzes how well implementation is meeting the challenge set by the World Health Organization (WHO) (1990) for comprehensive integrated primary mental health care.

Arising out of this analysis, I argue that the integration process is characterized both locally, and in other low-income countries, by an add-on approach, whereby psychiatry, with a focus on caring for the seriously mentally ill, is added to the workload of primary health care personnel. I argue that this will not achieve the vision of comprehensive integrated primary mental health care as outlined by the WHO (1990).

In Chapter Three, a conceptual chapter, I argue that this approach is a product of the reformist nature that characterizes the implementation of primary health care. I suggest that while the ideology of primary health care promotes comprehensive care, the implementation of the biopsychosocial model is reformist, and care thus remains largely biomedical and technicist in orientation. Furthermore, I suggest that while psychiatry is relatively easily compatible with a technicist approach to care, a comprehensive understanding of mental health care is not, hence the add-on approach. In view of this, I suggest that for comprehensive integrated mental health care to be effected in South Africa, a shift towards a comprehensive discourse of care at the primary level would be required.

In search of a more appropriate theory of healing which could underpin a comprehensive discourse of care, I suggest the adoption of a critical cultural understanding of illness, derived from medical anthropology. While this approach does not discard biomedicine, it provides an alternative paradigm for understanding ill-health, which would be more accommodating of a comprehensive discourse of care than the biopsychosocial model at the primary level of care.

These contextual and conceptual chapters of Section One establish the boundaries and questions of the research study reported on in Section Two. This research study was essentially concerned with developing an understanding of how a shift towards a comprehensive discourse of care, as conceptualized in Section One, could be achieved.

In pursuit of this aim, I developed, implemented and evaluated a reorientation and training programme designed to reorientate primary health care nurses towards the provision of comprehensive care. In the evaluation of this programme, I adopted both quantitative and qualitative in-depth case study research methodologies.

Given that a qualitative case study approach was adopted, this study does not provide conclusive evidence on the factors which mediate a shift towards a comprehensive discourse of care. Combined with programme research it does, however, provide intensive analysis of issues which mediated the capacity of the programme participants to provide comprehensive care. Furthermore, the study included broader specialist interviews which were less bounded by the case study approach. My methodology is described in Chapter Four.

With respect to the results and interpretation of the emergent data, which is contained in Chapter Six, I was informed conceptually by the model of

organizational change developed by the Tavistock Clinic. This model is described in Chapter Five, together with contextual information on the history and status of nursing in South Africa. This model adopts open systems theory in conjunction with psychoanalytic concepts in understanding organizational functioning and was deemed appropriate given that it provides a broad framework of analysis.

I integrate my findings, in Chapter Seven, to provide an understanding of factors which would need to be considered in order to effect a shift towards a comprehensive discourse of care. I argue that reorientation programmes for primary health care personnel, on their own, will not ensure such a shift. Central to this endeavour would be the need to restructure the health care system to contain anxieties associated with comprehensive care. In this regard, the health care system was found to function as a social defence system, being structured to contain anxieties associated with comprehensive care through supporting a narrow technicist approach to care.

Finally, I conclude with Chapter Eight which provides an overview of the pertinent themes which emerged in relation to closing the gap between policy principles and praxis. I have done this in relation to mental health care specifically, as well as extracting processes which I considered to have broader applicability to the transformation of society in general. Furthermore I have explored some of the limitations of this study and suggest a way forward.

SECTION 1

SETTING THE CONTEXT FOR RETHINKING COMPREHENSIVE INTEGRATED PRIMARY MENTAL HEALTH CARE

CHAPTER 2

TRANSFORMATIONS IN MENTAL HEALTH CARE: AN INTERNATIONAL AND NATIONAL PERSPECTIVE

2.1 Introduction

This contextual chapter provides an overview of efforts at transforming mental health care in low-income countries as well as in South Africa. From this overview, I suggest that there is an emphasis on developing community-based systems of care for patients with serious mental, particularly psychotic, disorders, at the expense of caring for patients with more common mental health and behavioural problems[1] at the primary level. This is problematic given the contribution that dealing with these problems can make to improving health status (e.g., Jenkins & Strathdee, in press). Furthermore, it is essential to facilitating the vision of comprehensive primary health care held by the WHO, and its member states. To quote Orley and Sartorius (1986):

> "for every single patient under the care of a health worker, attention should be given to that patient's psychological and social well-being. For whatever reason a person is brought into the health care system, he/she should be treated as a 'whole person' in a humane and caring way, taking account of the psychological and social, as well as the physical problems presented. It is this broad approach to care which the WHO has promoted through its mental health programme" (p.197).

[1] Common mental health problems refers to common mental illness and/or psychosocial problems. Common mental illness has been defined as "non-psychotic mental disorders (which) encompass a broad range of distress states which manifest with a mixture of anxiety and depressive symptoms" (Patel, 1998, p. 4). Behavioural problems refers to health related behavioural problems such as drug addictions which are often underpinned by psychosocial problems.

2.2 The shift to primary health care in low-income countries

The colonialist past of most low-income countries left behind a legacy of geographic, racial and class inequities with regard to access to western health care[2], including mental health care. Scarce resources were located mainly in urban centres, where there was an emphasis on the provision of hospital-centred, curative care. The recognition that this high technology and biomedically oriented hospital care was inappropriate in a context where resources were scarce, and where the bulk of illnesses were poverty related, led to the formulation of primary health care as a strategy to achieve health for all.

Primary care traditionally refers to first-level contact between patients and communities and organized health care (Starfield, 1992). It commonly includes services provided by peripheral health workers, inter alia, general practitioners, nurses and health auxiliary workers. Primary care is distinguished from primary health care, which adopts a biopsychosocial understanding of ill-health, and which is understood to have a much broader agenda. In this regard, in addition to essential health care services, it includes, inter alia, prevention and promotion activities.

Primary health care can further be distinguished into selective and comprehensive approaches. Selective primary health care targets specific problems through technicist interventions such as immunization and growth monitoring programmes, the idea being to target interventions which will reduce mortality and morbidity rapidly and at the least possible cost. While acknowledging the role of poverty and other social factors in the development of ill health, selective primary health care does not take responsibility for

[2] It should be noted that this chapter provides an overview of developments with regard to mental health care within the public health care systems of low-income countries, including South Africa. It is, however, acknowledged that mental health care is not the sole domain of the public health care system and that professional practitioners within the private sector, as well as indigenous healers and other care-givers contribute significantly to caring for people with mental health problems.

addressing these problems (Myburgh, 1989), and has thus been criticized for being reformist.

Comprehensive primary health care, on the other hand, is understood to adopt a development agenda whereby the root causes of ill health, such as poverty, are addressed. In this regard, it understands health as a development problem, requiring multisectoral intervention. Furthermore, health is understood holistically as the physical, mental and social well-being of the individual, as opposed to only the absence of disease. Moreover, another key feature of comprehensive primary health care is its emphasis on community participation and empowerment (Rifkin & Walt, 1986).

The birth of comprehensive primary health care is commonly attributed to the International Conference on Primary Health Care at Alma Ata in 1978 where it was defined as:

> "Care based on the needs of the populations...it is decentralized, requires the active participation of the community and family, and is undertaken by nonspecialized general health workers collaborating with personnel in other government and non-governmental sectors. These general health workers should be trained in the use of simple but effective techniques that are widely applicable, such as mobilizing community action, stimulating self-help groups, and providing health education, with particular emphasis on health promotion and disease prevention" (WHO, 1990, p.7).

The Alma Ata Declaration of 1978 has, however, been criticized, inter alia, for not promoting a development agenda which challenges the socio-economic relations of society (Myburgh, 1989). In this regard, Navarro (1998), suggests that the class relations of capitalist society underpins underdevelopment and impoverishment, which is at the root of ill-health for the majority of the population in low-income countries.

According to Myburgh (1989), in the Declaration of the Alma Ata, 'development' is, however, understood in relation to capitalist development, which is perceived to be intrinsically good. Furthermore, the terms health, health care, medical care, health care sector and health systems are used interchangeably (Myburgh, 1989). This is understood to have paved the way for selective primary health care, characterized by primary medical care services interspersed with targeted preventative programmes, as opposed to comprehensive primary health care, which has a development agenda (Rifkin et al., 1986).[3]

In keeping with the Alma Ata Declaration, many low-income countries embarked on a process of decentralization and the provision of primary health care. While these efforts have proved fruitful in terms of increasing life expectancy and reducing morbidity (World Bank, 1994), they have been criticized for being based, from 1983, predominantly on a selective primary health care approach, as opposed to comprehensive primary health care (Myburgh, 1989).

As such, primary health care has not necessarily impacted on poverty and underdevelopment which is at the root of a large number of health problems in low-income countries. A good example is provided by the inability of this approach to impact on the HIV/AIDS epidemic in South Africa, which has escalated from 0.76% in 1990 to 22.8% in 1998, with an estimated 3.6 million South Africans being infected with this deadly virus in 1998 (Abdool Karim & Abdool Karim, 1999). There is increasing evidence to suggest that AIDS campaigns with targeted health promotion activities are not effective, and that what is needed is a broad development agenda (Campbell & Williams, 1999).

[3] In this thesis, I have followed the convention of citing all the authors the first time the reference occurs and in subsequent citations, have included only the surname of the first author, followed by 'et al.'.

Furthermore, there is an increase in chronic mental illnesses and behavioural problems. Desjarlais, Eisenberg, Good and Kleinman (1995) attribute this to increased longevity :

> "Along with the increase in life expectancy has come an increase in depression, schizophrenia, dementia, and other forms of chronic mental illness, primarily because more people are living into the age of risk. Along with ... various social transformations have come a marked increase in alcoholism, drug abuse, and suicide. And while there has been declining maternal mortality, the incidence of violence against women, young and old, has increased sharply" (p.4).

I suggest that the lack of a development agenda in primary health care has, however, also a large role to play, with poverty being increasingly linked to mental illness (e.g., Saraceno & Barbui, 1997).

2.3 The shift to decentralized, integrated primary mental health care in low-income countries

The introduction of disability adjusted life years (DALYs)[4], a public health statistic which measures the loss of a healthy life, and which provides information on morbidity or dysfunction, has facilitated a better understanding of the impact of mental illness and behavioural problems on health than mortality rates. This is because the latter do not reflect the misery and suffering caused by mental illness and behavioural problems, nor their role in relation to mortality rates, as deaths are generally ascribed to their proximate causes (Desjarlais et al., 1995).

According to the WHO, using DALYs, the World Development Report of 1993 attributed 8.1% (revised upwards to 10.5% in 1996) of lost years to mental

[4] DALYs combine losses from premature death, defined as the difference between actual age at death and life expectancy at that age in a low mortality population, with loss of a healthy life resulting from disability (WHO, 1997).

health problems in all regions, except for sub-Saharan Africa (Jenkins, McCulloch & Parker, 1998). Furthermore, in terms of DALYs, while psychiatric and neurological conditions were estimated to account for an average of 28% of years lived with disability in all regions, sub-Saharan Africa was the exception, with disability resulting from psychiatric and neurological conditions being estimated at 16% (Jenkins et al., 1998). These discrepancies have been attributed to the higher rate of communicable diseases over noncommunicable diseases in sub-Saharan Africa (Jenkins et al., 1998).

In light of these statistics, while a low priority given to mental health problems in sub-Saharan Africa is perhaps understandable, it is surprising to find a similar pattern in most other low-income countries. To quote Desjarlais et al. (1995):

> "Yet despite the importance of these problems, they have received scant attention outside the wealthier, industrialized nations. In many poorer nations, government and health officials recognize the existence of these problems: faced with the choice of reducing deficits or establishing community health programmes, they opt for the former" (p.4).

Mental health services in low-income countries have been, in the main, only available at mental hospitals, often distant from people's homes. Furthermore, the care provided has been limited to custodial and psychopharmacological care of patients suffering from serious mental disorders, namely, acute and chronic psychotic and organic conditions (Ben-Tovim, 1987; Climent, Diop, Harding, Ibrahim, Ladrido-Ignacio & Wig, 1980). Transformation of these services has been slow, with the WHO having played, and continuing to play, a significant role in transformation of mental health services in many low-income countries.

In this regard, the WHO spearheaded a collaborative study for extending mental health care in low-income countries in 1975 (Climent et al., 1980; Harding, Busnello, Climent, Diop, El-Hakim, Giel, Ibrahim, Ladrido-Ignacio & Wig, 1983; Harding, Climent, Diop, Giel, Ibrahim, Murthy, Suleiman & Wig, 1983; Harding, De Arango, Baltazar, Climent, Ibrahim, Ladrido-Ignacio, Murthy & Wig, 1980; Murthy & Wig, 1983; Sartorius & Harding, 1983). This study was in response to the commitment by the WHO and its member states to comprehensive primary health care, which culminated in the Alma Ata Declaration. It was centrally concerned with establishing the feasibility of community-based mental health care through decentralizing and integrating mental health services into primary health care in low-income countries (Sartorius, 1978). Study areas in the following seven participating countries were identified: Columbia, India, Senegal, Sudan, Philippines, Egypt and Brazil.

The dominant strategy for integration used in all the study areas was training of primary health care personnel in the identification and management of patients with mental disorders. The approach to training varied, however, across the study areas as a result of differences in priorities, socio-cultural backgrounds, the professional orientation of the investigators, and the primary health workers involved (Harding, Busnello et al., 1983).

Key findings that emerged from the evaluation of the collaborative study included, in the first instance, that primary health care personnel, including community health workers, could successfully acquire and apply mental health skills through training (Climent et al., 1980). Furthermore, Sartorius et al. (1983) noted a shift in attitudes from initial resistance, to an acceptance of dealing with mental health problems, as well as an increased awareness of the importance of wider psychosocial issues in the production of ill-health.

2.3.1 Emphasis on developing community-based systems of care for serious mental disorders

It is important to note that the conditions identified as priorities in almost all the study sites were the more serious and organic conditions such as psychiatric emergencies, chronic psychoses and epilepsy (Climent et al., 1980). Consequently, dealing with more common conditions such as the 'neuroses' was limited in most areas due to resource constraints. Common mental disorders were in fact identified as a priority condition in only one area, namely, in Columbia (Harding, Busnello et al., 1983). It is therefore not surprising that Sartorius et al. (1983), in their evaluation, identified the need for further research into the management of the more common psychiatric problems at the primary health care level.

Furthermore, evaluation reports of integration efforts in other low-income countries outside of this study in the 1980s, reveal inconclusive findings with regard to how well primary health care personnel were able to deal with common mental disorders. In this regard, while the integration process in Guinea-Bissau included the training of primary health care personnel in the recognition and management of common mental disorders, evaluation of the programme showed no improvement in the identification and treatment of these disorders (De Jong, 1987; 1996). To quote:

> "they continued to medicalize neurotic and psychosocial problems and were not able to prevent maladaptive coping mechanisms. This situation would ... have improved if the nurses recognize(d) these conditions, stop(ped) their vicious cycle of medicalization and dependence, and refer(ed) patients to healers" (De Jong, 1987, p. 173).

Similarly, the decentralization and integration process in Botswana involved training of primary health care personnel to deal with both serious and common mental disorders. Ben-Tovim (1987) provides a detailed account of

his endeavors in this regard. While the evaluation of these interventions indicated a reduction in admission rates for institutional care for serious mental disorders, evaluation of the impact of the programme on the care of more common mental health problems was unclear. To quote:

> "Patients with non-psychotic distress were more prominent as new patients than might have been expected, but did not remain in contact to the same extent as patients with psychotic disorders. It is not clear from the data available whether non-psychotically distressed patients were actively discouraged from re-attending after their first appointment, or were dissatisfied with the treatment offered and so dropped out of care" (Ben-Tovim, 1987, p. 202 - 203).

With regard to more recent initiatives to develop community-based mental health services in low-income countries, while the identification and management of more common mental disorders by primary health care personnel forms part of the goals of integration, there also appears to be an emphasis on serious mental disorders. For example, the process of decentralization and integration in Tanzania has emphasized the development of psychiatric rehabilitation villages for the seriously mentally ill (Kilonzo & Simmons, 1998). Similarly, the development of mental health services in Cambodia centred around the development of mental health clinics to deal with severe, major mental health disorders and epilepsy (Somasundaram, Van de Put, Eisenbruch & De Jong, 1999).

Furthermore, a search of the website of the Nations for Mental Health Programme of the WHO in June, 1999, revealed a total of ten projects concerned with the issue of decentralization and integration of mental health care. The countries involved were Egypt, Ghana, Mongolia, Sri Lanka, Yemen, Argentina, Mozambique and Belize. While care for common mental health problems at the primary level may have been included in the goals of these projects, the indicators used to measure success of the projects suggest

an emphasis on decentralizing and integrating mental health care for the purposes of providing community-based care for patients with serious mental disorders. With the exception of Argentina (where strengthening community mental health programmes for the mentally ill following the phasing out of the psychiatric hospital formed the focus of the project), key indicators of all the other projects included a reduction in the number of psychiatric admissions and an increase in the number of patients successfully discharged. Improved identification and care of more common mental health problems were not included as specific performance indicators by any of the projects.

It should, however, be noted that there have been some specific projects which have targeted the training of primary health care personnel in the identification and management of common mental health problems. These include a project in Zimbabwe, where primary health care nurses were trained in the identification and management of depression. In this project, primary health care nurses were trained, using an algorithm, known as the Multiple Symptoms Card, to diagnose probable depression, followed by a seven step management plan (Abas, Broadhead, Mbape & Khumalo-Sakatukwa, 1994). Furthermore, the WHO has recently developed an educational package for primary health care providers which equips them with a number of algorithms for the identification and treatment of common mental disorders encountered at the primary level of care (WHO, 1998).

Notwithstanding these initiatives, the above review suggests, however, that while identification and care of common mental health problems forms part of the WHO's agenda for the integration of mental health care into primary health care (cf. WHO, 1990), it has not received the same emphasis as has the development of community-based systems of care for the seriously mentally ill. Furthermore, where evaluation studies of the provision of care for common mental health problems at the primary level have been

conducted, they have not painted a rosy picture (e.g., Ben-Tovim, 1987; De Jong, 1987).

The emphasis on developing community-based systems of care for patients with serious mental illness in low-income countries, mirrors the emphasis that has been placed on deinstitutionalization in high income countries, such as the United States and the United Kingdom. During the first half of the 20th century, prior to the introduction of psychotropic medication in the 1950s, custodial care had been the main source of care for patients with serious mental disorders in these countries. Given the anti-therapeutic nature of prolonged hospitalization (cf. Goffman, 1961), as well as the human rights abuses suffered by patients in some of these institutions (Ahmed & Plog, 1976), community-based care was regarded as the panacea to these ills. Furthermore, it offered the potential to reduce costs of caring for the mentally ill (Butler, 1993; Durham, 1989; Prior, 1991).

The introduction of psychotropic medication precipitated deinstitution-alization in high-income countries as it meant that psychiatric patients could be more effectively maintained in communities (Butler, 1993; Prior, 1991). In the United States of America, large scale deinstitutionalization resulted in a reduction in the number of psychiatric beds from 450 per 100 000 in 1955 to 110 per 100 000 in 1981 (Andrews, Teeson, Stewart & Hoult, 1990). Furthermore, this pattern was mirrored in the United Kingdom where there was a reduction in the number of psychiatric beds from 350 per 100 000 in 1955 to 133 per 100 000 in 1989 (O'Driscoll, 1993).

While there is evidence to suggest that community-based care can provide as good or even better outcomes for patients than in-patient care in both high and low-income countries (e.g., Ben-Tovim, 1987; Kiesler, 1982; Kilonzo & Simmons, 1998; Mosher, 1983), there is also increasing evidence to suggest that this is contingent on the type of care received by patients in the community.

The experience of the deinstitutionalization process in the United States and United Kingdom provides a clear illustration of this. In both countries, the deinstitutionalization process has been criticized for being driven by economic factors, with inadequate community-based rehabilitation programmes being established for discharged patients. This resulted in a large number of homeless mentally ill people (Durham, 1989; Lamb, 1993), and contributed to the 'revolving door' syndrome, which is characterized by patient relapse and hospital readmission (Butler, 1993).

Psychopharmacological care on its own has proved to be an insufficient intervention for community-based rehabilitation programmes. Instead, comprehensive programmes which involve a combination of medications and coordinated community or family-based rehabilitative and psychosocial interventions are increasingly being considered necessary (Desjarlais et al., 1995). Furthermore, Mechanic (1996) suggests that assertive community treatment programmes, which focus on bringing comprehensive rehabilitation programmes to patients and their families, have a positive cost-benefit outcome, but are not necessarily a cheaper treatment option to institutional care.

For deinstitutionalization to be effective, it is clear that resources need to follow the patient into the community for the development of comprehensive coordinated rehabilitation programmes. Furthermore, in the face of the appalling conditions of state mental hospitals in a number of low-income countries (Desjarlais et al., 1995; Kilonzo & Simmons, 1998), the need for the WHO to support deinstitutionalization programmes is thus obvious. Given that mental health resources in low-income countries are scarce, it is also understandable that priority, in relation to the use of *mental* health resources, be given to the provision of care for more serious mental health problems, as suggested by Orley and Isaac (1997). It follows, therefore, that integration projects supported by the mental health divisions of government

departments, as well as the WHO, would emphasize care of the seriously mentally ill at the primary level of care. I argue in section 2.7 that that this should not, however, be at the expense of caring for common mental health problems

2.3.2 Integration characterized by an add-on approach

In addition to an emphasis on the development of community-based systems of care for patients with serious mental illness, the integration process, in low-income countries, has also been characterized by an add-on approach, whereby psychiatry has been conceptualized as an additional component to be added to the workload of primary health care personnel. This is reflected in the training programmes which have focused on providing primary health care personnel with additional skills and tools (e.g., algorithms and checklists) to assist them in the identification and management of mental disorders (e.g., Abas et al., 1994; Ben-Tovim, 1987; De Jong, 1987; Murthy et al., 1983; WHO, 1998).

While primary health care personnel require this technical knowledge and skills base to identify and manage mental health problems, I argue in Chapter Three, that this approach on its own inculcates a technicist, biomedically focused approach to mental health care at the primary level of care, as well as reinforcing the dominant biomedical model of psychiatry.

The integration of mental health into primary health care as outlined by the WHO (1990), has, however, a much broader agenda. This agenda includes providing primary health care personnel with the necessary *orientation* and skills to provide holistic care, which would promote the WHO's (1990) definition of health as a state of physical, mental and social well-being. I argue in Chapter Three that such an understanding of health will not be achieved by the add-on approach to integration of mental health care, but

requires a reorientation of primary health care towards the provision of a comprehensive discourse of care, which would include mental health care.

2.4 The shift to primary health care in South Africa

The history of health services in South Africa mirrors the pattern of other low-income countries. In this regard, the bulk of the health budget was, under the apartheid government, devoted to high technology tertiary care (African National Congress, 1994). This emphasis was at odds, however, with the health status of the majority of the population who suffered mainly from diseases associated with poverty and social instability (Henry Kaiser Family Foundation, 1991).

To add to this problem, apartheid policies created racial inequities in access to health care. Public health care facilities were segregated along racial lines, there being 14 different health departments in 1990, with fewer resources allocated to African, coloured and Indian patients, than to their white[5] counterparts. To illustrate, in 1989, per capita expenditure on health was estimated to be R95 for Africans, R596 for whites, R339 for coloureds and R356 for Indians (Henry Kaiser Family Foundation, 1991).

While primary health care was adopted by the apartheid regime as a strategy for the provision of an 'effective and affordable' health service in South Africa during the 1980s (Kotze, 1990), it was conceptualized from the perspective of selective primary health care (Myburgh, 1989). As discussed, selective primary health care has been criticized for not promoting a development agenda which addresses the socio-economic and political underpinnings of ill health. The status quo is thereby maintained, with care

[5] Under the apartheid government, South Africans were categorized in terms of the Population Registration Act as white (refering to people of European origin); African (refering to people indigenous to Africa); coloured (refering to people of mixed race); and Indian/Asian (refering to people of Indian/Asian origin). As a result this categorization is pervasive in all health data heralding from the apartheid era).

remaining largely biomedical in orientation, interspersed with targeted prevention programmes for identified problems (Myburgh, 1989). Furthermore, the provision of primary health care under the apartheid era, came under severe attack from anti-apartheid activists for providing inferior health care for black citizens of South Africa (e.g., Buch, 1985).

The transition to a new democratic political dispensation in South Africa in 1994 heralded the restructuring of health care services to form one unified system organized at national, provincial and local levels. Furthermore, the development of a district health system based on the principles of *comprehensive* primary health care formed the foundation of the vision for the restructuring of the health care system, as contained in the White Paper on the Transformation of the Health System in South Africa (Department of National Health, 1997a).

2.4.1 District health system development in South Africa

The district health system, promoted by the World Health Organization as the mechanism to facilitate the delivery of primary health care (WHO, 1996), has been defined as follows:

> "A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly administrative and geographical area. It includes all the relevant health care activities in the area, whether government or otherwise. It therefore consists of a variety of interrelated elements that contribute to health in homes, schools, workplaces, communities, the health sector, and related social and economic sectors. It includes self-care and all health care personnel and facilities, whether government or nongovernmental, up to and including the hospital at the first referral level, and the appropriate support services, such as laboratory, diagnostic and logistical support. It will be most effective if coordinated by an appropriately trained health officer working to ensure as

> comprehensive a range as possible of promotive, preventive, curative, and rehabilitative health activities" (Tarimo, 1991, p. 4)

Key concepts underpinning the district health system are the concepts of decentralization and integration (Gilson, Morar, Pillay, Rispel, Shaw, Tollman & Woodward, 1996). With regard to *decentralization,* it implies a shift of functions, resources and authority away from centralized hospital-based care to the periphery (Collins, 1996). It thus has the potential to increase accessibility of health care services as well as allowing for more participation and accountability to communities serviced. To quote Collins (1996):

> "decentralization (is) a vital component of a policy, such as primary health care, designed to provide integrated processes of socio-economic development characterized by equity, a multi-sectoral approach to health development, and community participation" (p. 162).

Furthermore, in addition to increasing accessibility and facilitating community participation, one of the key advantages of decentralization identified by the World Bank (1994), lies in the potential for establishing continuity of care. This demands that the health care provider at the primary level of care, e.g., community clinic, establishes a long term relationship with patients that it services, and monitors their health and compliance with treatment regimes. To quote:

> "The health centre's comparative advantage lies in its accessibility and potential for communication with the community. Its scale of operations permits nurses to become acquainted with the households and their social environment, thus preventing drop-out and facilitating re-establishment of contact if the patient stops treatment" (World Bank, 1994, p. 58).

The concept of *integration* implies that the health care provider, e.g., community clinic, can perform several tasks concurrently. Integration thus demands that the many specialist services, including mental health care, that have been historically offered as vertical services, be integrated into the health care system at the primary level of care.

In relation to the implementation of the district health system approach in South Africa, a phased approach was adopted. In this regard, each province was initially divided into regions, which were then divided into districts, and where necessary, sub-districts or community areas (Department of National Health, 1996a). A regional level was considered useful to facilitate supervision of districts as well as the provision of referral and supportive services. District boundaries were determined on the basis that they were large enough to have the financial and management capacity to provide all essential comprehensive care up to first level hospital care; and small enough to facilitate efficient management and meaningful community participation and accountability. Internationally, district size varies from between 50 000 to 500 000 people (Mills, 1990). At the time of writing, despite enormous difficulties in the demarcation of district boundaries, 180 health districts had been demarcated nationally (Pillay & Pick, 1999).

Care at the district level constitutes the primary level of care within the health system. In terms of resources, mobile/community clinics, community health centres and district hospitals are located at this level and supported by specialist services at the regional level, with specialist hospitals being located at the tertiary level. In relation to management, district health committees with a district manager were to be established in each district, with community participation on these structures being a statutory condition (Freeman & Pillay, 1997). Furthermore, the district health committees were also required to collaborate with other governmental departments, non-governmental and private sector organizations across sectors to ensure the

provision of a full range of comprehensive primary health care services. At the time of writing, Pillay et al. (1999) indicated that three of the nine provinces of South Africa had appointed district managers in their respective districts.

With regard to the provision of comprehensive primary health care, this appears, however, to have remained largely at the level of rhetoric. Attention has been focused, in the main, on building primary health care clinics, with little attention being paid to the quality of care provided by these clinics. This is reflected in the Minister of Finance's Budget Speech in 1997 (Minister of Finance, 1997), where performance of the Health Department was reported in terms of number of clinics built, with 500 reported to have been built since 1994. No mention was, however, made of the quality of the service provided at this level of care. Furthermore, in the South African Health Review of 1998, Strasser and Gwele (1998) report that primary health care remains largely biomedical in orientation. While there are more primary health care clinics available, implementation, therefore, continues to be of a selective nature.

2.5 The shift to decentralized, integrated primary mental health care in South Africa

With regard to mental health services, as has been the case in other low-income countries, these services were historically geared towards providing care largely for the seriously mentally ill, with tertiary institutional care consuming 93% of the mental health care budget prior to 1994 (Freeman, 1992).

Furthermore, there were also racial inequities with regard to access and service provision. Fewer beds were allocated to black patients, whose treatment was limited to psychopharmacological and custodial care (Freeman, 1992). Moreover, a Report on Human Rights Violations and

Alleged Malpractices in Psychiatric Institutions (Department of National Health, 1996b) revealed human rights violations in several hospitals in South Africa, particularly in formerly black hospitals or formerly black sections of hospitals.

A further problem in relation to racial inequities, which persists to date, even though services have been integrated, is language. This limits accessibility to effective care. In this regard, with the exception of psychiatric nurses, the majority of mental health professionals are white and do not speak an African language. Adequate communication is, however, essential for adequate psychiatric care. To quote Drennan (1999), it is "a *sine qua non* of mental health care delivery" (p. 18). The paucity of African speaking psychiatrists and psychologists, which persists to date, thus serves to perpetuate a discriminatory psychiatric service (Drennan, 1999; Swartz, 1999).

During the apartheid era, the need, on the part of the Department of Health and Population Development, to keep abreast with international trends towards decentralization and integration, as well as be responsive to the needs of a changing South Africa was identified in 1991, when the shift towards more community-based models of care was first mooted (Freeman et al., 1997). This was later re-emphasized at a workshop hosted by the Department of Health and Population Development in 1993 to which individuals and organizations known to be in opposition to the government of the day were invited. This was in keeping with the period of political transition in which joint resolutions between government and its opponents were being sought. This workshop culminated in a report on guidelines for the delivery of mental health care in South Africa (cf. Parry, 1993), but was not translated into policy (Freeman et al., 1997).

Outside of government structures there was also a long tradition of opposition to government policy on mental health. A vociferous body was the

Organization of Appropriate Social Services in South Africa (OASSSA) which had the development of alternative policies as one of its stated goals (Freeman et al., 1997). Furthermore, there were many articles and conferences held which focused on the links between apartheid and mental health, and the need to develop more appropriate policies for mental health care for South Africa (e.g. Dawes, 1985; Nicholas & Cooper, 1990; OASSSA, 1986).

Leading up to the White Paper on the Transformation of the Health System in South Africa (Department of National Health, 1997a), a number of policy documents were produced. These included the Report on Mental Health and Substance Abuse (Department of National Health, 1995) which provided policy guidelines for the restructuring of mental health services in a post-apartheid South Africa. A broad understanding of mental health was adopted in which mental health problems were understood to encompass psychiatric disorders as well as problems arising from structural and social problems such as substance abuse, women and child abuse, violence, family breakdown, HIV/AIDS, etc. Accordingly, mental health services were understood as having to address both psychiatric and psychosocial problems.

This policy document culminated in the following policy principles for mental health care, as contained in the White Paper for the Transformation of the Health System in South Africa:

- A comprehensive and community based mental health and related service (including substance abuse prevention and management) should be planned and coordinated at the national, provincial, district and community levels, and be integrated with other health services provided.

- Essential national health research should include mental health and substance abuse to identify the magnitude of these problems.

- Human resource development for mental health services should ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care, based on primary health care principles. (This includes training in planning, implementing,

> supervising, monitoring and evaluating mental health care programmes; dealing with post-traumatic stress and the impact of violence; screening, counselling and identification. Drugs required for the management of psychiatric problems must be available at all levels of health care provision as appropriate) (Department of National Health, 1997a, p. 136).

Regarding the implementation of these policy principles, initiatives aimed at transforming the mental health care system have occurred in various provinces, with the Free State (formerly the Orange Free State) having started the process of decentralisation and integration as early as 1985 (Freeman, Lee & Vivian, 1994). The focus of this initiative was on deinstitutionalization and developing community-based services for patients with serious mentally illness. Over a ten year period, the number of psychiatric beds were reduced by one tenth, while community psychiatric services increased by five-fold (Freeman et al., 1994).

Furthermore, according to a recent study there appears to be general agreement amongst provincial mental health co-ordinators that the restructuring process essentially involves the following:

> "the provision of ongoing management of psychiatric patients with stabilised or chronic conditions in the community, as well as basic screening and emergency management by primary health care staff" (Flisher, Lund, Muller, Dartnell, Ensink, Lee, Porteus, Robertson & Tongo, 1998, p. 17).

There is also general consensus that training of primary health care personnel in the identification and management of psychiatric disorders is the mechanism to achieve this goal (Flisher et al., 1998). The result has been a plethora of training programmes, manuals and handbooks for the provision of mental health care in primary care settings (e.g., Allwood & Gagiano 1997; Clews & Thom, 1999; Robertson, 1996; Sawyer et al., 1996; Uys, Sokhela & Mkize, 1996). These products are reflective of the add-on approach adopted by

other low-income countries, providing primary health care personnel with checklists and algorithms for the identification and management of psychiatric disorders. Furthermore, while identification and management of common mental disorders, such as anxiety and depression, generally forms part of these programmes, the emphasis in implementation, as in most other low-income countries, is on serious mental disorders (Flisher et al., 1998).

This emphasis is reflected in the seven point plan of the Sub-directorate for Hospital and Community Services of the National Directorate for Mental Health. Only one of the points relates to community care, which is to be evaluated through a pilot deinstitutionalization project (Directorate for Mental Health and Substance Abuse, 1998). No mention is made of the need to evaluate care for common mental health problems. The focus of the National Department of Health is thus on serious mental disorders. Furthermore, deinstitutionalization has been identified as a national priority, with pilot deinstitutionalization projects having been established in two provinces (Dartnell, 1999).

2.6 The shift to decentralized, integrated mental health care in the province of KwaZulu-Natal.

KwaZulu-Natal, in which this study was located, has a population of eight million people which constitutes the largest population of all the provinces in South Africa (Flisher et al., 1998). In the face of this, it is however, poorly resourced with regard to mental health personnel relative to some other provinces. To illustrate, at the time of writing, while KwaZulu-Natal was home to 20% of the population of South Africa, it had only 11.5% of public sector psychiatrists and trainees, and 14.5% of public sector clinical psychologists and trainees. The Western Cape, on the other hand, which was home to only 11% of the South African population, had 41.3% of public sector

psychiatrists and trainees and 32.2% of public sector clinical psychologists and trainees (Flisher et al., 1998).

Furthermore, the bulk of mental health personnel have been located in tertiary hospitals or outpatient ambulatory care services. A recent survey on community/hospital staff ratios in South African mental health services showed that in KwaZulu-Natal there were 1510 specialist mental health staff attached to hospitals and hospital outpatient departments, compared to 66 attached to clinics and community health centres (Flisher et al., 1998).

Moreover, as has been the trend at a national level, the range of services provided has been restricted, in the main, to short and long term hospitalization and follow-up care of patients with serious mental illness, with a focus on medication as the dominant treatment modality. While some preventative and rehabilitative services for the chronically mentally ill and handicapped have been provided by government subsidized non-profit organizations, such as the mental health societies, these services have had an urban and racial bias, with more resources being allocated to the white population group (Edelstein, Webber & Pillay, 1997).

2.6.1 A framework for the restructuring of the mental health care system in KwaZulu-Natal

The framework for the restructuring of the mental health system in KwaZulu-Natal, depicted in Table 1 (see p. 33),forms the basis of the plan for the restructuring of mental health services in the province (Department of Health, KwaZulu-Natal, 1996). This framework had been developed by myself in collaboration with my colleagues (Petersen et al., in press). It was informed, in the first instance, by policy developments and principles for mental health care under the new dispensation; secondly, by a situational analysis of mental health resources in the province of KwaZulu-Natal; thirdly, by the work of the CMHP, which as already mentioned in Chapter

One, had been involved in the development of a district-based system of mental health care (cf. Petersen et al., 1996); and fourthly, by experiences of other countries, notably that of the World Health Organization in promoting the integration of a mental health component into primary health care in low income countries.

Caplan's concept of preventative psychiatry underpinned the suggested functions for health care personnel at district level. Caplan (1964) conceptualized prevention as occurring at three levels, viz. tertiary, secondary and primary prevention. Tertiary prevention is concerned with ameliorating long term symptoms of the psychiatrically ill through rehabilitation. Secondary prevention is directed at reducing the prevalence of disorders through early detection and treatment, while primary prevention focuses on reducing the incidence of disorders through addressing the causes of mental illness through health promotion and prevention activities.

Entry into the health care system in KwaZulu-Natal is understood to occur at the primary level of care at two points. The first point of entry occurs at the first tier which is serviced by non-professional community care-givers, such as community health workers, traditional healers and auxiliary health workers, although social workers are sometimes present in urban areas (see Table 1, p. 33). This is regarded as the community level of care, where home visits are conducted and community-based programmes provided. The second point of entry is at the second tier, which is comprised largely of professional primary health care nurses (see Table 1, p. 33), who operate from primary health care clinics and have difficulty conducting home visits due to their workload.

Table 1: Proposed mental health system to facilitate district-based mental health care in KwaZulu-Natal

Level of care	Human resource team	Functions
Tertiary level of care	**Tier 5**	
	Specialist tertiary hospital team Psychiatrists Psychologists Psychiatric Nurses Occupational Therapists Social Workers	▪ Provide long term in-patient care ▪ Provide out-patient care ▪ Provide training, support and back-up to district teams ▪ Plan and develop mental health services in the regions in conjunction with district teams
Secondary level of care	**Tier 4**	
	Regional mental health team Specialist Psychiatric Nurse Psychologist Occupational Therapist Social Worker Consultant Psychiatrist	▪ Provide short term in-patient care ▪ Assess, diagnose, prescribe, revise and initiate psychopharmacological treatment ▪ Provide psychological, occupational therapy and social work services ▪ Provide support and referral service to mental health programme coordinators ▪ Plan and develop mental health services for the districts in conjunction with psychiatric nurses in community areas
Primary level of care	**Tier 3**	
	Psychiatric Nurse (as district mental health programme coordinator) District medical officers	▪ Assess, diagnose, prescribe and initiate treatment ▪ Revise treatment ▪ Develop and implement community-based mental health programmes ▪ Referral to specialists and regional hospitals ▪ Consultancy-liaison service for primary health care nurses and community care-givers ▪ More specialized counselling ▪ Implementation of a health information system
	Tier 2	
	Primary Health Care Nurses	▪ Screening for mental health problems ▪ Emergency treatment of mentally ill persons ▪ Counselling ▪ Referral to tier 3 ▪ Basic rehabilitation ▪ Psycho-education ▪ Follow-up medication
	Tier 1	
	Traditional Healers Community Health Workers Auxiliary Workers Social Workers	▪ Promotion of mental health ▪ Recognition of mental health problems ▪ Referral to level 2 ▪ Basic counselling ▪ Support of mentally ill persons and families ▪ Psycho-education ▪ Basic rehabilitation ▪ Monitor patient adherence with prescribed drug regimens

Reproduced from Petersen, Bhagwanjee and Parekh (in press)

With regard to community care-givers at the *first tier*, it was suggested that primary prevention activities include the promotion of mental health through psycho-education and involvement in specific mental health prevention programmes, such as alcohol abuse prevention programmes, mental health awareness campaigns, etc. It was suggested that secondary prevention activities include case finding; referral of serious mental health problems, such as psychosis; and the identification and management of less serious transient and situational problems, using problem-solving counselling techniques.

It was further suggested that tertiary prevention activities include the provision of basic rehabilitation services for the chronically mentally ill. This was in keeping with proposals for integrated mental health care by the WHO (1990), as well as developments in other low-income countries, such as Botswana (Ben-Tovim, 1987) and Zimbabwe (Freeman, 1988), where there are also relatively few professionally trained health care personnel. Community-based rehabilitation of the chronically mentally ill requires inter alia: monitoring patient adherence with prescribed drug regimens; psycho-education and support to the patient and his/her family; as well as vocational development, social skills training and housing support. In view of these multiple aspects, the need for community care-givers to collaborate with services from other sectors, especially welfare, was deemed especially necessary, highlighting the importance of the establishment of multi-sectoral development committees at this level to facilitate this process.

Furthermore, monitoring of patient adherence with prescribed drug regimens was considered a particularly important function of community care-givers in the provision of community-based rehabilitation given that a high default rate was found in at least one of the community psychiatric clinic in KwaZulu-Natal (Petersen et al., 1997), and is likely to be common to most community psychiatric services. This results in the 'revolving door' syndrome which characterized the process of deinstitutionalization in the United States of

America and the United Kingdom in the 1960s, and is purported to be the result of a lack of adequate coordinated community care (Butler, 1993).

Within the proposed framework, primary health care personnel at the *second tier,* were expected to provide a secondary preventative service through (i) the identification and referral of serious mental disorders requiring specialist care to the next level of care; (ii) managing common mental disorders which are transient, of recent onset and/or situational, through problem solving counselling and basic behavioural techniques; and (iii) the provision of emergency treatment for psychiatric problems.

It was suggested that tertiary prevention at this level would take the form of follow-up care for the chronically mentally ill through monitoring and providing repeat medication prescribed by mental health professionals, as well as providing psycho-education for patients and their families (Roberston, Zwi, Ensink, Malcolm, Milligan, Moutinho, Uys, Vitus, Watson & Wilson, 1997; WHO, 1990). It was regarded as crucial that primary health care nurses provide follow-up medication for the chronically mentally ill, particularly at mobile clinic points and fixed community clinics, given the finding that the expense of traveling to the psychiatric clinic for medication was found to be one of the main reasons for the high default rate in at least one psychiatric clinic (Petersen et al., 1997). Furthermore, this would free community psychiatric nurses to be able to perform the functions outlined for them at the third tier.

The *third tier* constituted the referral level of care within districts. At this level it was suggested that a certain number of district hospital beds be allocated for short-term in-patient care. Furthermore, it was suggested that community psychiatric nurses be deployed on a permanent basis to districts/sub-districts, depending on population size, as district mental health programme coordinators. In this role they would be required to facilitate the development of district-based mental health care systems as well as provide

specialist support to general primary health care personnel. While recognizing that the existence of programme coordinators at district level could be interpreted as a continuation of vertical services, they have, however, been found to be useful in ensuring that priority issues are addressed in an appropriate and coordinated way (Bamford & McCoy, 1998; Lenneiye, Engelbrecht, Volkwyn, McCoy & Sanders, 1998).

The concept of district mental health programme co-ordinators is supported by the WHO on the basis that mental health care has historically been a neglected area. To quote:

> "One health worker - a psychiatric nurse, if one is available - should be responsible for coordinating mental health work in the district. He or she should see that a sufficient stock of medicines is available, co-operate with workers in other disciplines and sectors, organise orientation courses for community health workers and community leaders, and support the health centre and community health workers" (Tarimo, 1991, p. 52).

Lessons emerging from the experience of the United States' attempts to develop a community-based mental health care system also reinforce the need for district mental health programme coordinators. More specifically, a designated post to ensure the coordination of services was deemed necessary given the multisectoral nature of psychosocial rehabilitation (Burns, 1992).

In addition, generalist health care providers at the first and second tiers of care have been found to require both technical and emotional support (De Jong, 1987; Mau, cited in Swartz, 1998). District mental health programme co-ordinators would be well placed to provide this support.

Thus, the functions of the mental health programme coordinators at the primary level of care were envisaged to encompass the following: (i) to coordinate and monitor the development of community-based rehabilitation services and primary prevention programmes in conjunction with community

caregivers within their jurisdiction; (ii) to provide a consultancy-liaison service to community caregivers and primary health care personnel; (iii) to coordinate the development of multisectoral development committees in conjunction with community caregivers in their area; and (iv) to provide more specialist psychiatric care for more treatment resistant problems. With respect to the last function, it was suggested that referrals may need to be limited to severe cases as there is a danger that the existence of a specialist mental health care provider at district level may perpetuate a vertical service (pers. com. M. Lenneiye, WHO consultant to the Department of National Health, 1998).

The proposed first three tiers of mental health care thus occur at the primary level of care and are district-based. Furthermore, primary health care nurses are located at the second tier within the system and their roles and functions were clearly articulated in relation to the tiers below and above them.

Given the paucity of mental health specialists within the framework at district level, it was regarded as essential that a multidisciplinary mental health specialist team provide support to the districts at a regional level. While services at a regional level were conceptualized more broadly as the secondary level of care, in the framework provided in Table 1 (p. 33), it was conceptualized as the *fourth* tier in the referral chain. It was suggested that this tier of care be provided by regional mental health teams attached to regional hospitals and resourced by multidisciplinary teams of mental health specialists including psychiatric nurses, psychologists, occupational therapists, psychiatric social workers and consultant psychiatrists. The need for support for mental health care specialists at district level is reinforced by Flisher et al. (1998), who found that psychiatric nurses deployed at primary level care expressed the need for vertical support programmes.

Given that health care is to be managed at a district level (Pillay, Mzimba & Barron, 1998), it was envisaged that these teams would manage and coordinate the development of mental health services in conjunction with the

district management teams and mental health programme coordinators in the various districts. The regional mental health teams would thus be responsible for ensuring (i) the reorientation and training of community care givers, primary health care personnel and psychiatric nurses to service the districts; (ii) the provision of a multidisciplinary referral and support service as well in-patient care at regional hospitals; and (iii) the development of prevention and rehabilitation programmes in collaboration with mental health programme coordinators, primary health care nurses and community care givers.

The focus of the services provided at this tier would thus be on planning and implementing mental health services for the districts, as well as the provision of consultation and intervention for more severe treatment resistant problems such as eating disorders, parasuicide, severe emotional or family problems, personality disorders and child abuse or rape as suggested by Lazarus, Dartnell and Sibeko (1996).

A *fifth tier* of care was envisaged to be provided by tertiary psychiatric hospitals resourced by multidisciplinary teams including psychiatrists. At the time of writing, four such hospitals were being planned for the entire province of KwaZulu-Natal (Department of Health, KwaZulu-Natal, 1996). It was envisaged that these institutions would provide long term in-patient and out-patient psychiatric care. The primary objective of this tier of care would therefore be to provide consultation and specialized assessment and intervention services for more severe and complex problems requiring institutionalization, such as the psychoses.

Given the different levels of care being suggested as well as the multi-sectoral nature of rehabilitation programmes for the chronically mentally ill, it is essential that an efficient referral and information management system be established in order to ensure coordination between the different tiers and sectors of care. Poor information flows between different levels of care, particularly primary and secondary levels, was in fact identified as one of the

barriers to the successful integration and decentralization of mental health care into the health care system in the United Kingdom (Butler, 1993). Along with poor motivation on the part of primary health care workers, it was also identified as a barrier to successful integration in India (Murthy, 1992).

While the proposed system depicted in Table 1 (see p. 33) accommodates the provision of care for common mental illness at the first and second tiers, requiring that community care-givers and primary health care personnel manage these problems, the emphasis throughout the system is, however, on the development of a community-based system of care for serious mental illness. Furthermore, as in the other provinces, an add-on approach, characterized by training of primary health care personnel in the identification and management of psychiatric disorders using algorithms and checklists has been identified as the primary route to implementing this plan (Department of Health, KwaZulu-Natal, 1996).

2.7 Problems with the content and process of the integration process both nationally and locally

An overview of mental health policy development and implementation in low-income countries internationally, and in South Africa specifically, has revealed the following. In the first instance, there is consensus on the need to decentralize and integrate mental health care into the primary health care system. Secondly, this process is generally understood to include care for patients with serious mental disorders as well as those with common mental health problems and/or health related behavioural problems. Thirdly, at the level of implementation, in terms of process, an add-on approach has been adopted where primary health care personnel are trained in the identification and care of psychiatric disorders using algorithms and checklists. Finally, in relation to content, there has been an emphasis on developing systems of care for patients with serious mental illness.

Problems with the add-on approach, as well as the emphasis on the provision of care for serious mental disorders at the primary level of care, include the following:

2.7.1 Vision of comprehensive integrated primary mental health care

As will be discussed in Chapter Three, the add-on approach to implementation reinforces a biomedical approach to care at the primary level. With regard to mental health problems, this approach does not, therefore, promote a shift from the historical emphasis on psychiatric disorders towards the vision of *comprehensive* mental health care which has been struggled for over the years in South Africa.

Although there is debate about what constitutes a sense of well-being across cultures, in South Africa the vision of *comprehensive* mental health care has generally been understood to refer to a state of physical, spiritual and emotional well-being which is determined not only by the physical disease process, but also by social, cultural and material conditions (ANC, 1994; Freeman et al., 1997; Vogelman, 1986). This vision concurs with the concept of comprehensive primary health care which is understood to have a development agenda, and the WHO's agenda for the integration process which, as already mentioned, is to promote health as a state of physical, mental and social well-being.

I argue in Chapter Three, that adding a psychiatric component to the dominant biomedical approach to primary health care continues to emphasize the disease aspects of mental illness, and may thus be likened to 'old wine in new bottles'. As such, it will not fulfill the policy principles demanding the integration of *comprehensive* integrated mental health care at the primary level of care. This agenda demands that primary health care personnel have the necessary orientation and skills to provide comprehensive care which has a development agenda.

2.7.2 Epidemiological considerations

Patients with common mental and/or associated psychosocial complaints have been estimated to constitute one third of primary care patients (WHO, 1997). This stands in stark contrast to prevalence rates for schizophrenia which range from estimates of between 0.5% - 1.0% in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition; American Psychological Association, 1994) to an average of 0.3% over twelve studies in five low-income countries (Desjarlais et al., 1995). While patients with serious mental disorders are more disruptive and visible, the higher prevalence of common mental health problems suggests that the latter should not be marginalized in favour of caring for the former, which has been shown to characterize the integration process both nationally and locally.

To elaborate further, Blue and Harpham (1994) in their analysis of the World Development Report of 1993, highlighted depression as a major problem for women, accounting for 31% of neuropsychiatric disorders for women in low-income countries. Moreover, of the noncommunicable diseases in women in low-income countries, neuropsychiatric disorders were found to constitute the second largest burden of disease, with cardiovascular diseases taking first place (Blue et al., 1994).

With regard to sub-Saharan Africa specifically, Patel (1998) in a review of fourteen prevalence studies in primary health care settings, found that prevalence rates for depression ranged from 10% - 69%, with a mean prevalence rate of 21.8%. Furthermore, two South African studies of the prevalence of anxiety and depressive disorders in community settings revealed prevalence rates of 24.9% and 25% respectively (Bhagwanjee et al., 1998; Rumble, Swartz, Parry & Zwarenstein, 1996).

In the face of these high prevalence rates, research evidence suggests, however, that many of these common mental disorders are not identified or are misdiagnosed by primary health care workers. In this regard, Harding et al. (1980) in a study in four developing countries, found, for example, that primary health care personnel failed to detect up to two thirds of psychiatric cases. These findings have been supported by other researchers, e.g., Freeman (1991) and Goldberg and Huxley (1992).

One possible explanation is that in many societies, including sub-Saharan Africa, physical complaints are the preferred idiom of distress (Harding et al., 1980; Patel, 1998; Swartz, 1998). Consequently, intervention is commonly provided for these symptoms, with the underlying psychological and/or psycho-social problems remaining untreated by the primary health care workers, as found by De Jong (1987) in Guinea-Bissau.

To quote the WHO (1990):

> "Patients often see a health worker because of obvious psychological and emotional distress rather than obvious physical illness. Such patients frequently have physical complaints and it is vital that the health worker is able to recognize these as symptoms that may reflect psychological problems. Physical complaints are often a way of expressing psychosocial distress, and failure to recognize this can lead to a wastage of health resources" (p.10).

Furthermore, there is research evidence to suggest that patients are more satisfied with their medical care if psychosocial concerns are addressed and psychological interventions have also been shown to benefit patients with a variety of physical and mental disorders (e.g., Badger, Ackerson, Buttel & Rand, 1997).

In light of this, the need for primary health care personnel to provide care which would ensure the identification and treatment of these more common mental illnesses is further vindicated. Furthermore, this need is exacerbated by urbanization and westernization of populations in low-income countries. In this regard, while help for these problems has historically been sought from alternative networks of care such as indigenous healers, family members and community care-givers, Harpham and Blue (1995) suggest that with urbanization and westernization, there is an increasing demand on health and welfare systems in developing countries to provide care for these common mental illnesses. Moreover, a number of studies suggest that patients in low income countries utilize both western and indigenous systems of healing simultaneously (e.g., Abiodun, 1995; Freeman & Motsei, 1992; Korber, 1990; Maclachlan, Nyirenda & Nyando, 1995).

2.7.3 Cost of common mental health problems to the health care system

While psychiatric services do not pick up the tab for the cost of caring for common mental illnesses and psychosocial problems, primary health care services do. The cost to the health care system of treating these problems is, however, hidden, largely because, as discussed, these problems often present somatically and are treated as such. To quote Blue and Harpham (1994):

> "The problem of somatisation ensures that many common mental disorders go undetected and result in repeat appointments dealing with superficial physical symptoms, without consideration of the psychological aspects of a patient's problem. Not only does this result in considerable misallocation of resources, but it obscures the true levels of mental disorder within a community" (p. 10)

It is thus a mistake to consider integration of mental health care into primary health care as an additional burden. To quote the WHO (1990):

> "it is not a matter of *adding* a mental health component: there is overwhelming evidence that mental health problems are already present among general health problems, but that they are either unnoticed or ignored. Valuable resources are often wasted through failure to recognize these problems, which are therefore dealt with inadequately. This leads to patient dissatisfaction, chronicity, and further wastage of resources. By making health workers sensitive to the presence of mental health problems, and equipping them with the skills to deal with those problems, much wastage of effort in general health work can be avoided and health care can be made more effective... responsibility for mental health is not an extra load for primary health care services: on the contrary, it increases their effectiveness" (p. 11-12).

Integration of mental health into primary health care in South Africa has, however, been conceptualized as an additional burden. This is clearly demonstrated by a study conducted for the Department of National Health in which mental health care was conceptualized as an additional service to be provided at the primary level of care (Lazarus, Freeman & Rispel, 1995). The cost of the service was estimated to be in the region of R2,7 billion, more than 50% of the primary health care budget at that time, revised down to R560 million, or 13% of the primary health care budget (Rispel, Price & Cabral, 1996). This study presents, however, only one side of the coin, as the savings to the health care system through the provision of more effective and comprehensive care was not calculated.

The wastage of resources arising out of misdiagnosis and mismanagement of these problems has not been calculated for low income countries. In this regard, a Medline search of 226 citations and their abstracts on mental health in developing countries revealed no studies calculating the cost of misdiagnosis of common mental illness to the health system. Studies to this effect have, however, been carried out in high-income countries. Simon, Ormel, Von Korff and Barlow (1995), found, for example, in a study in the

ited States, a strong relationship between psychiatric disorder and overall lth care utilization, with costs associated with depressed and anxious ients being found to be one and a half times more than for other patients. is was attributed to the greater utilization of health care services by depressed and anxious patients. Mehl-Medrona (1998) found in rural primary health care clinics in the United States, that consistently high users of the service were more likely to be characterized by a higher degree of psychological distress, particularly depression. Lechnyr (1993) found that patients who require help with psychological problems, but do not receive it, visit doctors twice as often as those who receive care for such problems. He suggests that mental health care can reduce medical overutilization by up to 75%.

Furthermore, in relation to the economic burden of minor mental illness, it has been estimated to be more than $22 billion per year for depressive disorders in the United States (Gonzales, Magruder & Keith, 1994). Moreover, Jenkins (1985) in a study of civil servants in Britain found that the presence of minor psychiatric disorder was associated with increased levels of certified sickness absenteeism. Given that a prevalence rate of 33% was found, the economic cost of common mental illness as a result of absenteeism also needs to be taken into consideration. This is particularly important given Blue and Harpham's (1994) analysis of the World Development Report of 1993 which reveals that depressive disorders are largely associated with young adults belonging to the economically productive age group.

2.7.4 Promotion of negative attitudes

The add-on approach to integration which promotes the conception that mental health care is an additional burden at the primary level of care, also contributes to negative attitudes towards the provision of mental health care by primary health care providers. This has been reported both

internationally (e.g., Butler, 1993; Mechanic, 1992; Murthy, Un
locally (e.g., Lee & Zwi, 1997). Furthermore, the add-on appro he
encourage negative attitudes by communities towards the mentally il pa
psychiatry's nosographic orientation which may, in practice, lea Th
psychiatric labeling and encourage stereotyping and stigmatization of the
mentally ill (Kirkby & James, 1979).

2.7.5 The role of mental health in health promotion

Finally, comprehensive integrated primary mental health care is necessary for health promotion, particularly in dealing with health related behavioural problems, such as drug addictions and sexual practices, which may lead to increased sexually transmitted diseases, including HIV/AIDS. Health promotion is a key aspect of primary health care, being defined as a process which enables people to increase control over, and improve their health (Department of National Health, 1997b). As such, it necessarily involves dealing with psychosocial issues which underpin many behavioural related illnesses. This, in turn, demands that primary health care providers have the necessary psychological skills and orientation to undertake such care. The World Health Organization (WHO, 1990), in fact recognized this as being one of the key offerings that integration of mental health could provide to further the concept of primary health care. To quote:

> "human behaviour is an important factor in generating and maintaining disease, and effective prevention and treatment must therefore concentrate on changing behaviour. This requires the skillful application of psychological principles by all health workers" (WHO, 1990, p.10).

The absence of such skills, as well as the lack of a development orientation, runs the risk of reducing health promotion to 'advice-giving' at the primary level of care (Smith, Masterson & Lloyd Smith, 1999). This may create

further dependency on the health care system as opposed to empowering patients to gain control over their health.

Sexual practices, leading to increased sexually transmitted diseases, including HIV/AIDS, constitute a particularly important focus for health promotion intervention within the South African context. HIV/AIDS has reached epidemic proportions in South Africa and is increasingly being linked to poverty and disempowerment as well as sexual practices and sexual politics, such as polygamy, which exacerbate sexually transmitted diseases (e.g., Campbell et al., 1999).

Given that most sexually transmitted diseases are treated at primary level care, it is important that primary health care personnel not only treat the symptoms, but also adopt a development orientation in dealing with behaviours associated with sexually transmitted diseases. Furthermore, primary health care workers in sub-Saharan Africa are also increasingly having to deal with the medical and psychosocial sequelae of AIDS, which requires that they provide counselling and support in addition to symptomatic treatment (e.g., Kohi & Horrocks, 1993). The problem of AIDS thus highlights not only the need for psychological skills at the primary level of care, but also the need for comprehensive primary health care which has a development agenda.

2.8 Conclusion

With regard to the integration of mental health into primary health care in low-income countries, including South Africa, this chapter has shown that this task has been commonly approached from an add-on perspective. In this regard, a psychiatric component is added to the workload of primary health care personnel through training them in checklists and algorithms for the identification and management of mental disorders. Furthermore, there has

been an emphasis on developing community-based systems of care for the seriously mentally ill.

In light of the problems with the add-on approach as well as the demonstrated need for primary health care personnel to provide care for common as well as serious mental health problems, the need to explore why this trajectory exists, is thrown into sharp relief.

In the following chapter I argue that the reason for the add-on approach lies in the reformist nature with which primary health care has been implemented. While psychiatry is relatively easily compatible with biomedicine, comprehensive mental health care is not; demanding in fact, a comprehensive discourse of care at the primary level of care. Central to such a discourse of care is an empowering development agenda. While not discarding biomedical understandings of illness, such a discourse strives not to reify illness, but rather to contextualize the subjectivity of the illness experience for the patient within his/her socio-economic and cultural milieu.

CHAPTER 3

THE NEED TO TRANSFORM THE DISCOURSE OF CARE PROVIDED BY PRIMARY HEALTH CARE PERSONNEL

3.1 Introduction

In Chapter Two, I showed how, as in other low-income countries, the process of decentralization and integration of mental health into primary health care in South Africa, has been characterized by an emphasis on adding a psychiatric component to the workload of primary health care personnel. Furthermore; training of primary health care nurses in the identification and management of psychiatric disorders has been the strategy identified to effect these reforms. Moreover, while identification and management of common mental disorders, such as anxiety and depression, generally forms part of these programmes, the emphasis on implementation has been on caring for the seriously mentally ill. I suggested, inter alia, that this approach was problematic in that it would not facilitate the vision of *comprehensive* mental health care at the primary level of care.

In this chapter I examine in greater detail why this process has been characterized by an add-on approach with an emphasis on serious mental disorders. I suggest that the central problem lies in the reformist nature with which primary health care has been implemented. In this regard, while comprehensive primary health care espouses a development agenda, as discussed, at the level of implementation, it has been found to be characterized by a selective approach, which perpetuates a technicist biomedical approach to care (Strasser & Gwele, 1998). Furthermore, while psychiatry may be relatively easily compatible with this biomedical orientation, comprehensive mental health care is not.

To illustrate, it is relatively easy to treat serious mental illness such as schizophrenia from a biomedical perspective, as medication is one of the most common treatment strategies. Common mental health and behavioural problems, which have been found to be more obviously aligned to social and material conditions (cf. Al-Issa, 1995; Swartz, 1998) require, however, a development agenda to be effective. In this regard, technical solutions are much more difficult to come by, and challenge health practitioners to confront the core inequities in economic, gender and race relations.

I begin this chapter with an overview of biomedicine and its hegemonic hold over primary health care. I then go on to explore psychiatry as a specialty of biomedicine, and problems with the add-on approach. I argue that in order to achieve the vision of comprehensive mental health care at the primary level, a transformation in the discourse of care at the primary level to one with a development agenda, which would promote health as a state of physical, emotional and social well-being is necessary. I also argue that this development agenda of comprehensive primary health care has not been achieved, as the biopsychosocial model does not provide a sound theoretical alternative to biomedicine as a theory of healing. In fact it has been found to facilitate the extension of biomedical ideology into other spheres of life such as family and work relations (Armstrong, 1987). In search of an alternative paradigm of healing which could more adequately underpin a comprehensive discourse of care, I provide an overview of alternative approaches to healing within the social science literature, drawing heavily on medical anthropology.

3.2 Biomedicine and its influence over primary health care

Biomedicine is grounded in a Cartesian dualism which split human consciousness into body and mind. It arose in the late 17th century with the advent of medical science out of a struggle between religious explanations of

illness and scientific understandings, and according to Young (1987), heralded the disappearance of the experiencing person from health care. To quote Helman and Kirmayer (1988):

> "Biomedicine was founded on a Cartesian division of man into a soulless mortal machine capable of mechanistic explanation and manipulation, and a bodiless soul, immortal, immaterial, and properly subject to religious authority, but largely unnecessary to account for physical disease and healing" (p. 59).

According to Sullivan (1986), this earlier Cartesian dualism has been superseded by an 'epistemological dualism' which posits two different ways of knowing: subjective awareness and direct observation. Within biomedicine, the patient's subjective experience of distress is regarded as unreliable, with diagnosis being made on direct examination of the body. The real duality in modern medicine thus lies between the physician as active knower and the patient as passive known (Sullivan, 1986).

This approach is reflective of the dominance of scientific rationality over emotional and moral dimensions of illness within biomedicine. Furthermore, there is a distinction made between disease and illness. There are various definitions of this distinction, but the following encapsulates the key issues:

> "Disease stands for the biological disorder, or, more accurately, the physician's biomedical interpretation of disorder, while illness represents the patients personal experience of distress. In biomedicine, these two aspects of distress are accorded different status and it is 'real disease' that is viewed as the true object of medicine" (Helman & Kirmayer, 1988, p. 59 - 60).

This dualism underpins biomedical discourse which shapes western consciousness on illness and healing. According to Henriques, Hollway, Urwin, Venn and Walkerdine (1984), discourse is a practice of power relations and structure of knowledge which shapes much of social life. It is embedded within discursive practices which includes language and actions reflective of a set of attitudes, meanings and beliefs which shape subjectivity.

Biomedicine operates as a discourse in the following ways. In the first instance, the technical language and practices of medicine serve to reify illness as an objective technical problem, divorced from the person experiencing the illness, as well as the social relations and social issues which underpin the illness (Waitzkin, 1991). Through this process, the body is reduced to a passive entity subject to technical interventions. The person as an experiencing social being is effectively removed through the use of technical language and medical jargon, codes and acronyms which disguise the reality of illness, such as 'CA' for cancer, 'MI' for a heart attack (Helman & Kirmayer, 1988). Furthermore, medical practices serve to distance the experiencing person from the body as well. This is visible, for example, in hospital gowns which remove the individuality of patients; the manner in which cases are discussed in front of patients as if no person existed; and even the use of drapes to expose only the body area to be operated on. In this way a patient is reduced to a "technical problem of organs and blood" (Helman & Kirmayer, 1988, p. 61).

Secondly, Foucault (1980) suggests that medical discourse, along with other scientific discourses, plays an important role in social control. This is demonstrated through the manner in which doctors have been found to deal with contextual problems. These problems, which underpin many illnesses, particularly common mental health problems, are often a product of the social, economic and political structure of society, including such issues as class structure and the organization of work; gender roles and sexuality; and

aging and the social role of the aged (Waitzkin, 1991). Doctors have been found to deal with these problems in one of two ways. They may reduce them to technical problems, avoiding discussion on these issues by guiding the consultation back to the technical aspects of the illness through interruptions, cut-offs and de-emphases (Waitzkin, 1991). Alternatively, they may assist the service user to adjust or cope with the problem, more often than not with medication, although psychiatrists and related mental health professionals may utilize other devices such as relaxation techniques, counselling and family therapies (Waitzkin, 1991).

Waitzkin (1991) suggests that the social control function of biomedical discourse reinforces the status quo, excluding social change as a meaningful alternative. This is made possible by the power associated with professional medical knowledge which creates an asymmetry in the doctor-patient relationship in which the doctor assumes responsibility for the patient's health. To quote Helman and Kirmayer (1988):

> "When the physician perceives the patient as a sick body it is natural that he take over the parenting function, bypassing the patient's own self-knowledge and self-care as demonstrably incompetent" (p. 62).

This power is derived from the scientific respectability attributed to biomedicine as well as the increasing control that biomedicine has exerted over life and death.

While the biopsychosocial model within family medicine is posited to provide an alternative conceptual framework to biomedicine, which takes contextual issues into account through holistic care (Engel, 1977), it has been criticized for being reformist in nature. In this regard, it perpetuates the epistemological dualism posited by Sullivan (1986), in which the power relations between patient and practitioner are not challenged, and according

to Armstrong (1987), in fact facilitates the extension of biomedicine's influence into other spheres of life e.g., family life and occupational life. The holistic care of biopsychosocial medicine is therefore criticized for not providing an alternative conceptual framework, but rather serving to extend the sphere of biomedical influence:

> "holistic health presumes to *enlarge* the traditional sphere of medical (read 'allopathic') concerns from a narrow, largely technical focus on symptomatology and disease to a broadened domain including such salient health foci as nutrition, psychological and spiritual well-being, interpersonal relations and influences emanating from the environment (Lowenberg & Davis, 1994, p.581, my emphasis).

Primary health care, is also posited to provide an alternative conceptual framework to biomedicine. As with family medicine, health is understood holistically from a biopsychosocial perspective. In this regard, a patient's psychological and social well-being as well as their physical complaints require consideration. Furthermore, primary health care personnel are encouraged to not just treat the presenting problem symptomatically, but to explore and deal with the causes of the problem as well (World Bank, 1994). As discussed in Chapter Two, comprehensive primary health care expects practitioners thereof to adopt a development agenda and engage in health promotion activities; intersectoral collaboration; and empowerment of individuals and communities to increase control over, and improve their health.

Given the recognition that the main determinants of health (e.g., adequate nutrition, clean water, sanitation, adequate housing and employment) lie outside the health sector, health promotional activities outside of the health sector are also emphasized (Baum et al., 1995), with social reform being part of the development agenda. To quote Baum et al. (1995) "(health promotion) can be interpreted as setting out an agenda for social reform of societies to make them healthier and more equitable" (p. 150).

As such, primary health care is posited to provide an alternative conceptual framework to biomedicine in that, firstly, illness is not reified as a disease or divorced from contextual issues. Secondly, comprehensive primary health care is by its very nature 'political' in the sense that prevention and promotion activities demand development activities that go to the roots of ill health (Gear, 1989), and which may demand a transformation in social relations.

Thirdly, it also demands a shift in the traditional power relations that have characterized doctor-patient relationships to one where patients are empowered as opposed to one which creates dependency. Fourthly, community participation and community led health care demands that more credibility be given to indigenous solutions to health problems (Parfitt, 1999). As Ensink and Robertson (1999) suggest, in order to provide meaningful assistance, primary health care providers should engage with the experiences and beliefs of patients in relation to their illness.

In the face of these noble ideals, with the exception of a few circumscribed initiatives, the implementation of primary health care has been characterized, internationally and in South Africa, by a selective approach. Implementation has been reductionist and selective (Baum et al., 1995), and may also be regarded as reformist. In this regard, while the social and environmental correlates of ill health are recognized, implementation has focused on selective and targeted approaches which have stressed medically and behaviourally defined goals that can be measured (Rifkin et al., 1986).

Baum et al. (1995) suggest that this is a product of global economic policies which favour economic rationalism and profit at all cost. To quote:

> "Considerations of equity, intersectorality and community involvement were dismissed in favour of technical feasibility and cost-effectiveness of programmes" (Baum et al., 1995, p. 150).

While this may be true, I suggest that a further problem also lies in the biopsychosocial framework which, as has been argued by Armstrong (1987), does not challenge the power differential between patient and health care provider. While it raises awareness of the psychological and social correlates of ill health, they are often ignored in intervention. Furthermore, when they are addressed, the biopsychosocial model has also been shown to actually facilitate, through technicist interventions, the extension of biomedical control into other spheres of life.

As Rifkin et al. (1986) suggest, there needs to be more emphasis on process and change rather than technicist interventions in primary health care. I suggest that, at a process level, this needs to start with challenging the power differential between patient and health care provider. At the heart of the development agenda promoted by comprehensive primary health care is human development. It follows, therefore, that if primary health care providers are to implement a development agenda, at the epicentre is creating a more equitable and empowering relationship between patient and health care provider. This requires, however, a paradigm of care which does not perceive the patient as a passive entity to be acted upon, but rather perceives him/her as being able to contribute actively to the healing process. While it is acknowledged that addressing many of the social determinants of health are beyond the reach and capacity of the individual worker; facilitating human development through a more equitable and empowering healing relationship is not.

3.3 Adding a psychiatric component to primary health care: A critique of the psychiatric discourse of care.

As a specialty of medicine, psychiatry has historically understood mental illness from a psychoanalytic and/or disease perspective (Duffy & Wong, 1996). Both of these approaches interpret psychiatric symptoms as signs of underlying pathology, either psychic, as in the case of psychoanalysis, or

physiological as in the case of the medical model. The latter gained supremacy, however, as the model of choice largely through the success of psychotropic medication in the treatment of the chronically mentally ill, with the introduction of phenothiazines in the 1950's also facilitating more humane and community-based models of care for patients with chronic schizophrenia. This development gave psychiatry, which had historically been viewed as the Cinderella of medicine due to its reliance on theories from the social sciences, scientific respectability compatible with the rest of biomedicine (Kleinman, 1987). The importance of this respectability is reflected in the hegemony of the biomedical model within psychiatry, which persists to date. This is in the face of a long history of opposition spearheaded by the anti-psychiatry movement (cf. Ingleby, 1981; Laing, 1965; Szasz, 1961), as well as more recent research which suggests the biosocial origins of mental illness (Eisenberg, 1995). In this regard, research on the neuronal structure of the brain suggests that it is plastic and modifiable through the sociocultural environment as well as through psychotropic medications and psychotherapy (Castillo, 1998).

Psychiatry, in the main, as a specialty of biomedicine, perpetuates a narrow biomedical discourse of care in relation to mental illness as well as other psychosocial and emotional problems that people may experience. Furthermore, the ease with which non-medical mental health care providers such as clinical psychologists, psychiatric social workers and psychiatric nurses have been seduced into playing a supportive role to psychiatry, is also reflective of the power of the biomedical model. Sharing some of the power associated with biomedicine is understood to be a motivating factor behind this association (Parker, Georgaca, Harper, McClaughlin & Stowell-Smith, 1995). Given that psychiatry does have such a strong following amongst non-medical mental health professionals, it should therefore be noted that, while this critique focuses on psychiatry, much of it also applies to clinical psychology, psychiatric nursing and psychiatric social work.

3.3.1 Psychiatry as a universalist approach

Biomedical discourse in psychiatry is promoted through the universalist approach which dominates western psychiatry. Universalism has been described by Swartz (1998) as:

> "the belief that Western psychiatry has discovered the core syndromes, and different manifestations in different parts of the world are unusual versions of these syndromes". (Swartz, 1998, p. 13).

Signs and symptoms are used to make a diagnosis of an underlying disease and, based on the scientific respectability of biomedicine, psychiatry assumes applicability to all people (Fabrega, 1996). As with physical illness, through directing a patient's responses to objectified symptoms, signs and treatments, mental illness is reified, and treated as a thing divorced from social relations and social issues that often underpin personal troubles (Swartz, 1998; Waitzkin, 1991). To quote Swartz (1998):

> "Mental illnesses, to varying degrees, are viewed as things and not processes which happen both to people and between people. Viewing mental illness as a thing is an example of what is known as *reification* - a process of viewing social relationships as fixed and static entities" (p. 13).

In this process, there is a reduction of human suffering into technical pathophysiological and personality problems which effectively reduces the potential to criticize the social relations and social issues which may underlie problems. Furthermore, there is a loss of lay conceptualizations and meanings of mental illness for the patient.

> "The professionalization of human problems as psychiatric disorders...causes sufferers (and their communities) to lose a world, the local context that organizes experience through the moral reverberation and reinforcement of popular cultural categories about what life means and what is at stake in living" (Kleinman, 1995, p. 117).

The universalist approach in psychiatry is clearly evident in the DSM IV (American Psychiatric Association, 1994). While the other diagnostic system, the ICD 10 (ICD-10 Classification of Mental and Behavioural Disorders; WHO, 1992), also assumes universality of mental illness, the DSM IV is widely used in the South African context, and thus forms the focus of discussion here.

The DSM IV is based on the DSM III, the purpose of which was to provide a classification system that could have universal applicability for making psychiatric diagnoses (Swartz,1998). It adopted an empiricist and descriptive perspective with regard to etiology. This 'scientific' medical approach, whereby pathology could be identified and categorized using abstract general rules, provided a nosological system to facilitate diagnoses on the basis of observable signs and symptoms. On the positive side, this system was useful for facilitating diagnostic labeling as well as a common understanding of disorders by clinicians of various theoretical persuasions (Swartz, 1998).

While social and cultural factors were accounted for to some extent by the multiaxial diagnostic system (Swartz, 1998), the DSM III was, however, widely criticized for the lack of attention paid to cultural factors, which decreased its universal applicability (cf. Mezzich, Kleinman, Fabrega & Parron, 1996).

Accordingly, the DSM IV was developed, in part, out of the need to address this problem. It has, however, been criticized for failing to implement many of the recommendations of the National Institute of Mental Health Group on Culture and Diagnosis which had the task of culturally enhancing the DSM IV (cf. Mezzich et al., 1996).

Attempts by the authors of the DSM IV to take the social and cultural etiology of mental illness into consideration, should, however, be acknowledged. In the first instance, Axes IV and V of the multi-axial diagnostic system are concerned with the impact of psychosocial factors on a person's social functioning as well as overall level of functioning.

Furthermore, users of the DSM IV diagnostic system are alerted to the need to consider the role of ethnic and cultural factors in the development of mental illness. Firstly, cultural nuances in the presentation of disorders are discussed throughout the text. Secondly, a guideline for the 'cultural formulation' of a patient is contained within the appendices, which also contain the third mechanism; a glossary of culture-bound syndromes (Swartz, 1998). These attempts to address the social and cultural etiology of mental illness are, however, considered inadequate for the following reasons.

In the first instance, while the biopsychosocial model on which the multi-axial diagnostic system is based, may create an awareness of psychosocial problems, it does not ensure that their role in the etiology of mental illness is considered, nor that these problems are addressed as part of the treatment plan. Kleinman (1987) for example, in his analysis of psychiatric care, found that psychiatrists generally perceive psychosocial problems as being an epiphenomenon of the underlying disease process as well as the responsibility of 'allied' mental health professionals, such as social workers and psychologists. While the biopsychosocial model creates an awareness of

psychosocial issues, it does not therefore ensure a paradigm shift away from the predominant biomedical approach that characterizes psychiatry.

The same argument applies to the introduction of a schemata for a cultural formulation of problems. Kleinman (1996) suggests that this runs the risk of 'window dressing' as is often the case in the clinical application of Axes IV and V. Moreover, the concept of culture bound syndromes has also been criticized. This concept is defined by the DSM IV as "recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM IV diagnostic category" (American Psychiatric Association, 1994, p. 844). In understanding the role of cultural formations in the development of mental illness, much of the critique of culture-bound syndromes stem from the notion that *all* psychiatric disorders can be understood as culturally constituted to some extent (Littlewood, 1996). Further, given the changing nature of cultural and social formations, which is exacerbated in a rapidly creolizing world, Bibeau (1997) suggests that culture bound syndromes are unlikely to remain constant, thus rendering classification into recognizable categories difficult.

3.3.2 The role of socio-cultural factors in the development of mental illness

Using schizophrenia as an example, while there is evidence to suggest that it is inherited, recent research suggests that the prognosis and course of the illness is effected by socio-cultural factors (Desjarlais et al., 1995). This is based on evidence from two WHO studies, viz., the International Pilot Study on Schizophrenia (IPSS) (WHO, 1979), as well as the Determinants of Outcome of Severe Mental Disorders (DOSMD) (Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day & Bertelsen, 1992), both of which

showed better outcomes for schizophrenia in centres which were defined as representative of the 'developing' world.

Swartz (1998) provides a succinct overview of studies which have since tried to explain these findings. He cites a recent study by Craig, Siegel, Hopper, Lin and Sartorius (1997), who, upon re-analysis of the DOSMD data, suggest that the centre has more of a role to play in the course of schizophrenia than the 'development' status of the country in which the centre was located. In this regard, they found that Prague and Nottingham, both centres in 'developed' countries showed outcome patterns which were similar to those of centres in 'developing' countries, with the exception of Cali. Swartz (1998) regards this as exciting information as it has the potential to start unpacking the cultural effects on outcome of schizophrenia. To quote:

> "When we know more of what we are talking about behind the labels of cultural difference and the developed/developing divide, then we will have more accurate information of use to people with schizophrenia and those wishing to help them" (Swartz, 1998, p. 213).

Desjarlais et al. (1995) summarise some possible effects of culture and social factors on the course and prognosis of schizophrenia. In the first instance, it has been suggested that better outcomes may be a product of greater support provided by extended family systems and communities in developing countries (e.g., Ben-Tovim, 1987; Kleinman, 1996), although research on expressed emotion suggests that more tolerant family attitudes towards family members with schizophrenia may be a better predictor of outcome (Swartz, 1998).

Secondly, conceptions of the course and cause of schizophrenia held by members of a particular society has also been posited to influence outcome.

In this regard, Waxler (1977), suggests that the attribution of mental illness to supernatural causes in Sri Lanka may account for better outcomes in this country, with the idea that attributing mental illness to an external force which can be removed, influences the responses of people who are ill as well as those around them. A person who believes they can get better is more likely to do so than someone who believes they have a chronic incurable disease. Similarly, if this belief is shared by those around the sufferer, they are more likely to support him/her in this endeavour.

Thirdly, incorporation of people with mental illness into a working role in their communities, which may be more possible in rural economies, has also been linked to better outcomes (Warner, 1994). To quote:

> "There can be little doubt that it is simpler for a schizophrenic person to return to a productive role in a non-industrial community than in the industrial world. The merits of tribal and peasant labour systems are apparent...it is easier for family and community members to reintegrate the sick person into the society, and the psychotic person is better able to retain his or her self-esteem. The result may well be not only better social functioning of the psychotic person but also more complete remission of the symptoms of the illness" (Warner, 1994, p. 159).

A good example of this is the success of Tanzania's psychiatric agricultural rehabilitation villages which are designed to provide the social milieu of rural villages in terms of productive activities and economic self-reliance (Kilonzo & Simmons, 1998).

As suggested by Craig et al. (1997), in order to understand the processes that occur within the black box of cultural effects there is the need for further research on the effects of stigma, family support, availability of treatment

and rehabilitation services, social relationships, and employment opportunities for the disabled on outcome of schizophrenia.

There are few studies into the cultural effects on the course of schizophrenia in South Africa. It would be interesting to see, for example, whether the conceptualization of mental illness in societies indigenous to South Africa, where mental illness is largely attributed to external forces, has any effect on outcome. Ngubane (1977) suggests, for instance, that within Zulu culture, mental disturbance is interpreted as the intrusion of alien spirits which must be removed. The 'victims' consequently receive the support, sympathy and attention that they require. Furthermore, within the Zulu cultural belief system, if a patient has *amafufunyane* (a type of spirit possession which is often diagnosed within psychiatric settings as a form of psychosis) the patient is believed to be susceptible to further attacks. Consequently, care is taken by the patient's family to shelter the person from future stressful situations (Ngubane, 1977).

3.3.3 Psychiatry's compatibility with the biomedical aspects of primary health care

In view of this critique of psychiatry, I suggest that psychiatry may be compatible with the dominant discourse of biomedical care which underpins the biopsychosocial model at the primary level of care for the following reasons. In the first instance, the reification of mental illness within universalist psychiatry neglects the subjectivity of the illness experience for the patient and the impact this may have on the course of illness. This approach is thus compatible with biomedicine. It is, however, of concern given the research evidence discussed above which suggests that socio-cultural factors have a profound influence on the prognosis and course of mental illness. Furthermore, the need to consider such factors is exacerbated

by South Africa's multicultural society, exemplified by the fact that we have eleven official languages. This context demands a discourse of care which takes cognizance of different cultural formations of illness and treatment modalities and which strives towards an approach which is accommodating of a variety of conceptions of illness and healing.

Secondly, as has been shown, the biopsychosocial model within psychiatry, as with primary health care, is reformist in nature. While raising an awareness of contextual issues, most intervention goes little further than family therapy, with treatment normally focused on assisting the patient to cope with the presenting problem, either through medication, counselling or behavioural techniques. While this is commensurate with the selective and targeted approaches within primary health care, it is problematic, particularly considering that the links between South Africa's apartheid history and people's mental health have been well established over the years (e.g., Dawes, 1985; Vogelman, 1986). This history has impacted on the social fabric of our society resulting in pervasive psychosocial problems manifest in high rates of interpersonal violence, gender and age-specific forms of violence, trauma, alcohol abuse and neurosis. The contextual nature of these problems thus demands multifaceted development interventions over and above focused medical, behavioural and psychological interventions.

Thirdly, psychiatry, as a specialty of biomedicine, has the potential to reinforce the unequal power differential which characterizes the biomedical relationship. It is associated with passivity and reliance by the patient on the health practitioner to provide a 'cure' for a technical biomedical problem. This is antipathetic to the empowering relationship arguably required for psychological intervention (Seedat & Nell, 1992), as well as for primary health care where the user is encouraged to increase control over his/her health.

While much of the literature explores this unequal power relationship in relation to medical practitioners, this relationship has also been found to characterize the nurse-patient relationship at the primary level of care (Mgoduso & Butchart, 1992; Rispel & Schneider, 1991). This is not surprising given the need for nurses to share some of the power associated with biomedicine (Holden & Littlewood, 1991; Rispel et al., 1991). There is a danger, therefore, that integrating mental health care into the primary health care system through only adding a psychiatric component to the workload of primary health care personnel will thus serve to entrench the existing power dynamics and work against the vision of comprehensive integrated mental health care.

To conclude, this section has highlighted the reformist nature of the implementation of primary health care. Furthermore, I have shown how psychiatry may promote a biomedical discourse in relation to mental health care. In view of this context, it is therefore not surprising that adding a psychiatric component to primary health care forms the favoured approach to integration. An add-on approach is, however, unlikely to achieve the vision of comprehensive integrated mental health care in South Africa. In order to achieve this vision, I argue that what is required is a shift towards a comprehensive discourse of care at the primary level. At the heart of such a discourse of care is an empowering relationship between patient and healer, where the subjectivity of the illness experience of the patient is taken into account, and where illness is understood as an interaction of physical, psychological and social dimensions that cannot be addressed separately as focused interventions. The following section represents a search for an alternative theory of healing to the biopsychosocial model which would promote such a discourse of care.

3.4 A comprehensive discourse of care? The search for a theoretical alternative

In search of a conceptual approach to health care which would facilitate a comprehensive discourse of care, this section provides an overview of some alternative approaches to healing within the social science literature and more specifically medical anthropology. This is done with the view to extracting aspects that would be useful for such a discourse. Following this, suggestions have been made for a theoretical alternative to the biopsychosocial model, which, as has been argued, is ultimately underpinned by biomedicine, resulting in a reformist approach to the implementation of primary health care. While not diminishing the important contributions of biomedicine to health care, I suggest an approach which is integrative of cultural and critical perspectives on illness.

3.4.1 Biological/evolutional theories of illness

Biological/evolutionary theories of illness understand ethnomedical systems to be socio-cultural adaptive strategies to environmental and/or biological changes (Hahn, 1995). Within this tradition, illness representations and ethnomedical healing systems are conceptualised as 'lay health beliefs' understood to be a set of adaptive responses to diseases which exist independently of culture. These 'beliefs' are distinguished from scientific biomedical 'knowledge' (Good, 1994).

This approach has been used as a means to further the ends of the social control function of biomedicine. In this regard, Farmer (1997) uses a South African example to illustrate how by attributing lack of compliance by tuberculosis patients to traditional beliefs held by Xhosa-speaking patients,

contextual issues such as poverty and the lack of health services for black patients were not considered as factors contributing to this problem.

Within psychiatry these evolutionary and biological models of ethnomedical systems are thus representative of a universalist approach and compatible with biomedicine. They are representative of the 'old transcultural psychiatry' which has been criticised for being reductionist through neglecting to consider the role of cultural systems as well as broader macro-economic issues in the determination of sickness and healing in societies.

3.4.2 'Meaning centred'/cultural interpretive approach

Consequently, in the last few decades, cultural and critical theories of illness have been in ascendancy in the social science literature. Cultural theories have been largely characterised by the 'meaning-centred' tradition or cultural interpretive approach which understands the phenomenology and course of illness to be shaped by culture and to emerge from an interaction between biology, social practices and meaning (Good, 1994). It is asserted that "sickness is constituted and only knowable through interpretive activities" (Good, 1994, p. 53). Further, interpretive activities are located within semantic networks of associative meanings which are linked to fundamental cultural values within a society. Consequently, healing systems play a large role in the construction of the illness experience for the sufferer as well as determining the illness trajectory.

As an approach, the meaning centred tradition has been strongly represented in the work of Kleinman (1980), having its roots in his concept of explanatory models of illness. An explanatory model of illness refers to how a person interprets an illness episode in terms of cause; description of precipitating

events and initial symptoms; description of the sickness; expected course of the sickness; and understanding of available treatment modalities (Hahn, 1995). Kleinman (1980) suggested that explanatory models of illness vary across cultures, with biomedicine forming the explanatory model of illness within western culture. As such, biomedicine forms part of western cultural ideology relating to illness and healing, having achieved legitimacy through its scientific, technical base. Biomedicine adopts a disease view of ill health whereby meaning is attributed to symptoms only in relation to physiological states. Illness is, however, conceptualised more broadly to incorporate its 'meaning' for the patient and the way in which the sick person, his/her family and social network construct or perceive, label, explain, evaluate and respond to sickness (Good & Good, 1993).

The interpretive approach thus offers an alternative paradigm for viewing ill health demanding that the subjectivity of the illness experience for the patient is taken into consideration. It has, however, been criticised by critical theorists within medical anthropology for neglecting to pay sufficient attention to the role of broader socio-economic and political forces, including power relations, in the construction of illness representations and healing systems (e.g., Baer, 1997; Singer, 1990).

3.4.3 Critical approach

The critical approach locates the ethnographic study of illness and health care historically within the broader context of macrosociety, adopting a critical or neo-Marxist approach to the analysis of illness representations and medical understandings. According to Singer (1990), there is a need to understand:

> "health issues in light of the larger political and economic forces that pattern interpersonal relationships, shape social behaviour,

> generate social meanings, and condition collective experience" (Singer, 1990, p. 181).

In contrast to the interpretive approach, proponents of the critical approach understand meanings attributed to illness to also be constructed from where an individual is located within a particular society socially, economically and politically. Further, understanding power relations in a society is regarded as key to making sense of illness and healing.

Critical medical anthropologists have, however, largely focused their attention on understanding the role of biomedicine on health and health care in western society. As discussed, through interpreting illness as problems of individual pathophysiology and personality, biomedicine is understood to effectively depoliticize the role played by society in the development of individual distress. Illness thus becomes decontextualized and dehistoricized from its social origins. In Good's (1994) words:

> "(the) transformation of political problems into medical concerns (is) akin to 'neutralising' critical consciousness, and is thus in keeping with the interests of the hegemonic class" (Good, 1994, p. 58).

Furthermore, biomedicine is understood to reinforce dominant ideological systems of capitalist society through conveying ideological notions of desirable behaviour related to work, family and other spheres of life. This is made possible by the legitimacy it holds in western society which, as discussed, was achieved and is maintained through its scientific technical base. Moreover, the micro-politics of the doctor-patient interaction, which is characterised by a power differential between doctor and patient (Waitzkin, 1991) is understood to reinforce this ideological role.

physical environment. Within these limits, human societies and their cultures are understood to influence illness through construction, mediation and production. Culture constructs the way that we understand sickness and healing through a set of ideas (ideological notions of illness) transmitted to members of that society through social interaction, language etc. Mediation of illness occurs through access to health resources as well as common understandings of treatment modalities. Further, a society and culture may in fact play a role in the production of illness through, inter alia, diet, air pollution or belief systems, such as the belief in the healing capacity of medicines in biomedical tradition.

Baer (1997) stresses the importance of a synthesis of the biocultural and critical approaches in understanding illness formations. This is based on an understanding that nature and the political economy as well as social relations are interpenetrating.

Central to integration of the critical and cultural interpretive approaches is that the meaning of illness within different cultures is placed within historical and prevailing socio-economic and political conditions. This concurs with Singer's (1986) view:

> "While a critical perspective asserts that, in the final analysis, macrolevel structures and processes are dominant, and that much past work in medical anthropology has not sufficiently attended to this fact, it also maintains that a thorough understanding of any particular issue requires exploration of microlevel phenomena. Herein lies the unique contribution of local populations and their lifeways, world views, and motivations for action, to the encompassing holism of the political economic approach" (Singer, 1986, p. 128).

Adopting an integrative approach of the cultural interpretive and critical traditions thus demands that the practitioner place the patient's explanatory model of illness within a wider understanding of the social, economic and

political structures of the society in which the patient lives. To quote Keesing (1987):

> "Without such an articulation to wider questions of social theory, interpretive anthropology will be myopic, self-indulgent, and ultimately sterile" (Keesing, 1987, p. 166).

An approach integrative of the critical and interpretive perspectives does not only rely, therefore, on local explanations or narratives of illness but takes a reflexive position, understanding these to be culturally constituted idioms of distress located within broader issues of power and ideology of the society in which the patient is located. Furthermore, it cautions against the idealization of traditional explanatory models of illness which may privilege certain members of society as well as those that may be harmful to patients.

3.5 A conceptual model for a comprehensive discourse of care

As a theoretical alternative to the biopsychosocial model of primary health care, which has been shown to be implemented in a reformist manner which promotes biomedical ideology, I suggest an illness perspective which is integrative of the critical and interpretive perspectives discussed above. This would require a conceptual shift from understanding ill health from a disease perspective to one where the subjectivity of the illness experience for the patient is also taken into consideration. I suggest that such a conceptual shift would facilitate a comprehensive discourse of care in the following ways.

In the first instance, it would accommodate the socio-cultural correlates of illness. This is particularly important with regard to mental illness in the South African context given the links between social problems, including apartheid and poverty on mental health, as well as the diverse cultural explanations of illness. Furthermore, the shift towards primary health care

and community-based mental health care requires far greater involvement of patients and families in their health care. As Ensink and Robertson (1999) suggest, in order to provide meaningful care, this shift has made the need to engage with the belief systems of patients and their families even more pressing. To quote Desjarlais et al. (1995):

> "Any effort to provide mental health care or clinical services must .... begin with an understanding of local forms of distress and illness, systems of signs and meanings used to interpret illness and organize responses, and local systems of care" (Desjarlais et al., p. 51).

Secondly, the incorporation of a critical understanding of illness construction cautions against idealizing the meaning centred approach. The latter has the capacity to privilege a patient's explanatory model of illness which may, in fact, reflect cultural ideologies and disguise inequities in the distribution of power, knowledge and privilege within the society of which the patient is a part (Swartz, 1999). It demands that the role of these broader socio-economic and political issues which contribute to the development and maintenance of illness are identified, and brought to awareness with the view to empowering both healer and user to act on these issues. Illness may, for example, be used to negotiate power relations. This is exemplified by the phenomenon of 'nerves' in medical anthropology. Lock and Scheper-Hughes (1990) suggest that 'nerves' is not only an illness representation of depression, but also plays a role in negotiating power relations.

Thirdly, given Foucault's (1965; 1973) understanding of the role of the clinical gaze of biomedicine in surveillance and control, a critical understanding would demand a critical reflexivity on the part of health professionals in relation to their role in upholding power relations within society (Foster & Swartz, 1997). The proposed integrative approach has the potential to facilitate a shift in the nature of the power relations which

dominate the patient-healer relationship as it demands such a reflexivity on the part of the health care provider. Furthermore, through engaging with the patient's explanatory model of illness, the traditional power differential between patient and health care provider would be challenged, as patients would be invited to participate in knowledge production on illness and healing. As discussed, a model of care which challenges the power differential between patient and health care provider is regarded as being at the epicentre of promoting the development agenda of comprehensive primary health care.

Given that discourse is embedded in language, an appropriate place to begin this process would be to challenge the use of the term 'patients' to refer to users of health care services. This term is linked with passivity, dependency and being acted upon. This position of the 'patient' in health care is inimical to comprehensive primary health care which demands a discourse of care which empowers individuals and communities to increase control over their health.

Based on these arguments, I suggest that an integrative approach based on critical and cultural understandings of illness would provide primary health care practitioners with a conceptual model of ill-health which would be more appropriate to meeting the goals of comprehensive primary health care than the biopsychosocial model. Only on the return of the experiencing person to the healing relationship will we be able to achieve a service which promotes health as a state of physical, emotional and social well-being, with mental health being an integral component.

There are a number of approaches which have been developed to tap the explanatory models of illness held by patients. Several explanatory model interviews have been developed as research tools (e.g., Weiss, 1997). Henbest and Fehren (1992) promote a 'patient-centred' approach to care where the

patient's thoughts, feelings and expectations are considered in addition to symptoms. The model which has informed the reorientation programme developed in this study was that of Katon and Kleinman (1980) who provide a useful clinical social science approach which can be practically applied by clinicians.

With regard to this approach, the health care provider is generally required to understand firstly, the user's understanding of the causation of their illness; secondly, the disease problems as well as illness related problems; and thirdly, that consensus be reached between the health care provider and the user regarding the cause, diagnosis and optimal treatment for the problem. This search for consensus is referred to as illness negotiation and is regarded as particularly important in situations where the user holds alternative understandings of their illness.

The integration of critical aspects into this framework would demand that the health care provider, in addition to rethinking all disorders in cultural terms, also contextualizes the meanings attributed to illness within an understanding of the socio-economic and political relations of society. This would demand that they have some understanding of the nature of the socio-economic and political dynamics of the user's culture and that the meaning attributed by the user to his/her illness is interpreted within this context.

Furthermore, the roles of health care providers would need to be expanded to include that of (i) consciousness raiser, as these issues would need to be brought to the awareness of the user; (ii) facilitator, as users would need to be empowered to act on these problems; and (iii) advocate and activist, as a return to the more radical agenda of primary health care demands a transformation of the social relations of society.

Moreover, given the power differential that traditionally exists between patient and healer, the critical approach would also demand a critical reflexivity on the part of health practitioners. In this regard, they would need to guard against using the negotiation model of the meaning centred approach to manipulate users into shifting their explanatory models towards theirs (the health care providers), as Scheper-Hughes (1990) suggests may happen.

3.6 Conclusion

In this chapter, I provided a critique of both primary health care and psychiatry, showing how the biopsychosocial model which underpins both, is implemented in a reformist manner which reinforces a narrow biomedical ideology. I suggested that the favoured approach of adding a psychiatric component to the workload of primary health care personnel is thus understandable, given the compatibility of the two. I also showed how the add-on approach would be unlikely to achieve comprehensive integrated mental health care, and argued that what was needed was a shift towards a comprehensive discourse of care at the primary level. In search of a conceptualization of health care which could support such a discourse, I provided an overview of alternative theories of healing within the social science literature, suggesting an approach integrative of cultural and critical understanding of illness.

While acknowledging the centrality of biomedicine to health care, this conceptual framework demands, however, that the subjectivity of the illness experience for the patient **also** be considered and that it be located within the social and economic relations of society. By doing so it would support a comprehensive discourse of care which, in addition to providing technical biomedical interventions, also acknowledges the role played by socio-economic relations and culture in the construction of the illness experience.

Furthermore, it demands a critical reflexivity on the part of health practitioners as to their role in upholding power relations of society. It challenges the historical power differential between health care provider and patient, which has been argued, is central to the development agenda of comprehensive primary health care.

To conclude, the fundamental difference between the 'add-on' approach to integration of mental health and the approach being suggested is that due regard needs to be taken of patients' illness experiences, as opposed to just the disease aspects. Through engaging with a patient's explanatory model of illness, the traditional power differential between patient and health care provider may be challenged and human development, which is the key to social development, encouraged. This demands however, a shift in the discourse of care provided.

The following section reports on a research study designed to develop an understanding of the issues that require consideration in facilitating a shift towards such a comprehensive discourse of care at the primary level.

SECTION 2

FROM POLICY TO PRAXIS: DEVELOPING AN UNDERSTANDING OF HOW TO EFFECT A COMPREHENSIVE DISCOURSE OF CARE AT THE PRIMARY LEVEL.

Introduction

I argued in Chapter Three that for comprehensive integrated mental health care to be effected at the primary level in South Africa, a shift towards a comprehensive discourse of care would be required. In line with this argument, the aim of the research component of this dissertation was, therefore, to develop an understanding of the issues that require consideration to effect such a shift. This section reports on my research efforts to this end. My investigation comprised two phases.

First phase

The first phase entailed the development, implementation and evaluation of a reorientation programme designed to equip primary health care nurses with the necessary skills and orientation to provide comprehensive care. Reorientation programmes have been suggested as the route to achieving comprehensive care by primary health care personnel in South Africa (e.g., Van Niekerk & Sanders, 1997).

Primary health care nurses were targeted as they form, in the first instance, the backbone of the primary health care system in South Africa, and particularly in KwaZulu-Natal (Strasser et al., 1998), where this study was located. Given the paucity of medical doctors, particularly in rural areas, they function as 'mini-doctors', diagnosing and treating the commonly occurring illnesses at this level of care (Schneider, Malumane, Ngwenya & Blackett-Sliep, 1989). Secondly, while nursing practice, including primary health care nursing, is based on holism underpinned by the biopsychosocial model, it has been found, in practice, to be characterized by a biomedical task oriented approach to patient care (Littlewood, 1989; May, 1995; Strasser et al., 1998). The need for primary health care nurses to be oriented to the provision of comprehensive care was therefore indicated.

Objectives

The objectives of this first phase were threefold:

1. To develop and implement a reorientation programme to equip primary health care nurses with the necessary skills and orientation to provide comprehensive care.

2. To establish how successful the reorientation programme was in effecting a shift towards a comprehensive approach to care by the nurse participants.

3. To develop an understanding of the factors which mediated the capacity of the nurse participants to provide comprehensive care following their participation on the reorientation and training programme.

Research questions

In order to meet the second two research objectives I needed to answer the following research questions:

1. *Did the reorientation programme effect a shift towards comprehensive care by primary health care nurses?*

2. *What were the factors which mediated the capacity of the nurse participants to provide comprehensive care following the reorientation and training programme?*

Second phase

Given the iterative nature of qualitative research, the second phase of the study emerged out of the first phase in that it was concerned with understanding factors which impede the transformation of the health care system to being supportive of a comprehensive discourse of care at the primary level. The need for this investigation developed out of the findings of the first phase which pointed to the need for a contextual understanding of nursing practice where nursing was understood to be embedded within, and upheld by, the health care system. Reorientation programmes alone, were therefore understood to be insufficient to transform the care provided by primary health care nurses.

Given that psychiatric services would need to be restructured in support of comprehensive integrated mental health care at the primary level as discussed in Chapter Two (see Table 1, p. 33), it was deemed important to gain an understanding of factors which may impede this process from the perspective of psychiatric personnel. Furthermore, specialist interviews with key individuals in management positions were also deemed appropriate.

Objective

The fourth objective was thus as follows:

4. To develop an understanding of factors which impede the transformation of the health care system to being supportive of a comprehensive discourse of care at the primary level.

Research question

In line with this objective, I needed to answer a third research question:

3. *What factors impede the transformation of the health care system to being supportive of a comprehensive discourse of care at the primary level?*

Use of a case study approach

The collection of data in the first phase was bounded by the use of a case study approach. The case study was a sub-district of the Outer-west District of the Durban Functional Region, namely, KwaDedangendlale (see Figure 1, p. 3). The main reason for choosing this sub-district was due to easy access as a result of my involvement in the area for a number of years through the CMHP. As discussed in Chapter One, the CMHP was concerned with developing a district-based mental health system in this area (cf. Petersen et al., 1996).

The second phase was less bounded as it involved specialist interviews with managers in key positions as well as focus group interviews with psychiatric nurses, and thus reflected concerns beyond the confines of the case study area.

Overview of this section

In terms of an overview of this section, I begin with Chapter Four which provides a brief overview of the development of the reorientation programme which constituted my first objective. The details of the reorientation programme are contained in Appendix 1. Furthermore, the research design and methods of data collection and analysis for the remaining objectives are also outlined in this chapter. Chapter Five provides information on the conceptual framework used for the analysis of the emergent data, as well as contextual information on the history and status of nursing care in South Africa. This is followed by Chapter Six which reports on the findings pertaining to all three research questions, namely, how successful the

reorientation programme was in effecting a shift towards a comprehensive approach to care by the participants; the factors which mediated their capacity to provide comprehensive care; and finally, factors understood to impede the transformation of the health care system to being supportive of a comprehensive discourse of care. Finally Chapter Seven, provides an integration of these findings.

CHAPTER 4

RESEARCH METHODOLOGY

4.1. Introduction

I begin this chapter by providing an overview of the reorientation programme and research methodology used for the first phase. With regard to the latter, I provide an overview of evaluation research as well as a rationale for the qualitative and quantitative methods used. Furthermore, the research design, data collection techniques, methods of analyses and ethical considerations for both the quantitative and qualitative aspects are also provided. This is followed by a brief overview of the research methodology of the second phase which was essentially comprised of qualitative interviews.

4.2 First phase

4.2.1 The reorientation programme

The development and implementation of the reorientation programme, which constituted my first objective, was provided as a component of a broader training programme for primary health care nurses in mental health care. While it formed the basis of the initial two modules of this training programme, it also provided the necessary framework and approach for the rest of the modules which covered the identification and management of both serious and common mental health problems occurring at the primary health care level in the sub-district. These included the psychoses, organic mental disorders, depressive disorders, anxiety disorders, substance abuse disorders and common psychosocial problems such as rape and partner abuse.

The programme was run as part of an in-service training programme for primary health care nurses on a weekly basis over ten weeks. Each session lasted approximately five hours. Principles of adult education drawn from Paulo Freire's critical pedagogy (cf. Freire, 1972) and problem based learning (cf. Schmidt, Lipkin, De Vries, & Greep, 1989) informed the didactic method adopted. In this regard, existing knowledge amongst the participants was used as the basis for learning. Participants were encouraged to draw on their own experience and to reflect critically on this. Furthermore, they were encouraged to implement new approaches and reflect on their experiences in this regard at the subsequent sessions. To illustrate, they were encouraged, inter alia, to reflect critically on the disjuncture between nursing theory, which is based on holistic care, and their practice of nursing which was largely technicist; the causes of mental health problems in the sub-district, and what appropriate intervention would entail; as well as their role in providing largely biomedical technicist care at the primary level.

Given that the study reported on in this thesis is only concerned with the evaluation of the reorientation component, I have only provided an overview of this component of the programme.

The development of the programme

The development of the reorientation component was grounded in the first instance by my reading of the literature and conceptualization of comprehensive care discussed in Chapter Three. Secondly, it was informed by my experience of attempting to implement a district mental health care system in the KwaDedangendlale community (cf. Petersen et al., 1996), which was part of the work of the CMHP. Thirdly, I also drew on my experience of attempting to incorporate a critical cultural perspective into the training of community-based intern psychologists.

With regard to the last aspect, the development of a community-based internship programme for counselling psychologists was part of our efforts in the Psychology Department at the University of Durban-Westville to transform the curriculum for the professional training of psychologists to one which was more accommodating of the needs of the majority of South Africans. This community-based internship programme is located within the CMHP and was accredited by the Health Professions Council of South Africa in 1996. The purpose of this programme was to provide intern psychologists with exposure to working at a primary health care level as opposed to only at a tertiary level of care, as well as to deal with problems experienced by working class rural communities, as opposed to the problems experienced by middle class urban communities, which have been historically characterized training programmes in South Africa.

Community psychology formed the overarching theoretical framework for the internship programme, with the intern psychologists required, inter alia, to engage in primary, secondary and tertiary mental health prevention activities. Activities included the provision of a training and consultation service to community and primary level care-givers; and the provision of a referral psychological service to the KwaDedangendlale community, where the CMHP had been involved in developing a district mental health care system.

The client base of the referral psychological service was comprised largely of referrals from the primary health care nurses. Common problems seen included depression, anxiety and other associated psychosocial and interpersonal problems. Furthermore, many of the clients held traditional beliefs in relation to their illness. Consequently, this provided a useful setting for developing new models of care which incorporated critical and cultural elements into the healing relationship.

A brief overview of the reorientation programme

As a more detailed description of the reorientation programme is provided in Appendix 1, I have only provided a brief overview here. In the first instance I introduced primary health care nurses to the policy principles underlying the shift to comprehensive integrated primary mental health care in South Africa. Furthermore, the implications thereof for the roles and functions of primary health care personnel and psychiatric personnel at district level were explored. Secondly, problems with the add-on approach to integration were discussed in relation to the participants' understanding of psychiatry and how well it addresses the socio-economic and cultural roots of mental health problems they encountered in the communities they serviced. The participants were also required to reflect on what appropriate intervention would entail and their feelings in this regard. Thirdly, the participants were required to reflect on the disjuncture between the holism of nursing theory and the practice of nursing, with its subsumption by the medical system, and the implications that this had for the care they provided. In this regard, they were asked particularly to reflect on how the provision of biomedically oriented care increased their power and status within the communities they serviced, as well as within the health care system. Fourthly, using problem-based learning, a critical meaning centred approach to patient care was introduced as an alternative theoretical framework to the biopsychosocial model. In this regard, the clinical social science approach suggested by Katon and Kleinman (1980) was adapted to incorporate critical aspects. Furthermore, Leininger's (1988) model for the provision of culture-centred care was used to assist in illness negotiation. Leininger (1988) suggests three possibilities for the provision of culturally congruent care: preserving the cultural orientation; negotiating some change in the cultural orientation; or repatterning the cultural orientation which involves persuading the patient to diverge from traditional healing practices if they are harmful to the patient or his/her family.

While the participants were required to reflect on their feelings towards such an approach to patient care, the programme also provided some

Furthermore, they were both trained in the use of the other indicators to ensure that they had a common understanding of what the indicators were measuring.

The indicators were based on the content of the reorientation programme described in detail in Appendix 1. Four dimensions were identified, namely: (i) qualities necessary to facilitate comprehensive care; (ii) microcounselling skills to facilitate exploration and understanding; (iii) problem identification using the framework provided by the meaning centred approach; and (iv) problem management (see Table 2, p. 95).

The indicators developed to measure qualities necessary to facilitate comprehensive care were accurate empathy, nonpossessive warmth and genuineness. These indicators were chosen on the basis that they have been identified as the three ingredients necessary for an effective therapeutic relationship (cf. Truax & Carkhuff, 1967). In this regard, Truax and Carkhuff (1967) provide research evidence which suggests that counsellors and therapists who have high levels of empathy, warmth and genuineness produce positive changes in their clients, while those who are low on these qualities produce deterioration or no change in their clients.

The indicators chosen to measure microcounselling skills were use of minimal encouragers, reflection, clarification, and paraphrasing and summarizing. These were identified using Ivey's (1994) understanding of the microcounselling skills necessary to promote understanding of the presenting problem. (See Appendix 1 pages 270-271 for a fuller description of these indicators.)

The indicators developed to measure problem identification were identified using Katon and Kleinman's (1980) adapted framework for the clinical social science evaluation of problems. This framework involves a number of steps including the need to initially elicit the patient's perception of his/her illness, known as the patient's explanatory model of illness. This thus constituted the first indicator identified on this dimension. The next stage involves the

need to inquire about associated illness problems, which constituted the second indicator on this dimension. The third stage involves negotiating a common understanding of the problem and intervention, which was used as the third indicator. The final stage is the development of a common biopsychosocial and cultural understanding of the problem, which constituted the fourth indicator identified on this dimension.

As Katon and Kleinman (1980) suggest, this approach should complement traditional psychological and psychiatric evaluation techniques as well as serve to improve the quality of clinical relationships and the effectiveness of care. Furthermore, they suggest that it offers a mechanism for providing culturally appropriate care and increasing patient satisfaction.

The indicators developed to measure problem management were: (i) inviting the patient to participate in the generation of solutions to the problem (step2 of the problem management model); (ii) reaching consensus on appropriate interventions (step 3 of the problem management model); and (iii) empowering the patient to act on these interventions (steps 4 to 7 of the problem management model). (See Appendix 1 pages 272-273 for a description of the problem management model.)

Table 2 Indicators of Comprehensive Care

Skills for comprehensive care	Indicator
Relationship skills/qualities	• Empathy • Nonpossessive warmth • Genuineness
Microcounselling skills	• Use of minimal encouragers • Reflection • Clarification • Paraphrasing and summarizing
Problem identification using the framework provided by the meaning centred approach	• Understanding the patient's explanatory model of illness. • Inquiring about associated illness problems • Reaching a common understanding of the problem and its treatment • Developing a biopsychosocial and cultural formulation of the problem
Problem management	• Inviting the patient to participate in the generation of solutions to the problem • Reaching consensus on appropriate interventions • Empowering the patient to act on these interventions

Using the transcripts of the nurse-patient consultations both before and after the reorientation and training programme, blind ratings by the two independent judges for each nurse participant on all these indicators were obtained. A four point scale of absent, poor, present and good was used. (See Appendix 2 for the ratings given by the independent judges on the transcripts of the consultation sessions before and after the programme using subject 5 as an example, pages 274-303. Transcripts and ratings of the other subjects are available on request.)

Analysis of the ratings on the indicators of comprehensive care before and after the programme involved firstly, an assessment of inter-rater reliability for the two independent judges. This was obtained by calculating the percent agreement between the two raters which is commonly used or recommended for categorical data (Barlow & Hersen, 1984). Given that the nurses were rated on an ordinal scale, categorical data was obtained by collapsing the four point scale to create categorical data of either inadequate (ratings of absent or poor) and adequate (present or good) and calculating the percent agreement. While Cohen's Kappa provides a chance-corrected measure of agreement and is thus considered preferable for categorical data (Howell, 1997), the small sample of nurses (5) in this study precluded the use of inferential statistics.

Secondly, mean difference scores between the pre-assessment ratings and the post-assessment ratings on the different indicators were calculated to assess programme effects.

4.2.5. Qualitative study design

The quantitative study was embedded within the qualitative research design, which was much broader and constituted the major focus of the first phase of the study. This was in view of the fact that, while I was concerned with establishing whether the reorientation programme had effected a shift towards comprehensive care by the participants (my second objective), I realized that this programme constituted only one aspect required to

facilitate such a shift. Given that my overall aim was to establish how such a shift could be achieved I thus needed to gain an understanding of the factors which mediated the participants' capacity to provide comprehensive care following the reorientation and training programme (objective 3). In pursuit of this objective, I chose to use the case study approach.

4.2.5.1 Case study approach

Stake (1994) distinguishes between intrinsic, instrumental and collective case studies. An intrinsic case study is undertaken in order to develop a better understanding of a particular case, divorced from the need to understand some abstract construct or phenomenon. An instrumental case study, on the other hand, is undertaken in order to provide insight into an issue or to refine theory, while a collective case study supposedly provides better understanding of the issue under investigation by virtue of having more cases (Stake, 1994). My study falls within the category of an instrumental case study approach as I was concerned with developing an understanding of the factors mediating the capacity of primary health care nurses to provide comprehensive care, using one sub-district as a case study. Stake (1994) describes an instrumental case study as follows:

> "The case is of secondary interest; it plays a supportive role, facilitating our understanding of something else. The case is often looked at in depth, its contexts scrutinized, its ordinary activities detailed, but because it helps us pursue the external interest...The choice of case is made because it is expected to advance our understanding of that other interest" (Stake, 1994, p. 237).

The case study approach was therefore considered useful in that it had the potential to facilitate intensive research on the factors mediating the capacity of primary health care nurses to provide comprehensive care. Furthermore, while it would not provide me with conclusive evidence on

these factors, it had the potential to facilitate the exploration of general processes and how they impact on a specific example (Hammersley & Atkinson, 1983).

In light of this, I considered the case study approach appropriate for meeting my concern of contributing to knowledge-building and theory development, which could inform the implementation of policy imperatives calling for the integration of comprehensive mental health care into primary health care in South Africa. In this regard, Sayer and Morgan (1985) suggest that intensive research methods are closely related and well suited to policy evaluation in that they provide a better basis for recommending policies than extensive research, which aids policy analysis through picking out general trends and patterns.

Given the intensive analysis of case study research, it is therefore not surprising that Stake (1994) suggests that qualitative case studies lend themselves well to naturalistic, ethnographic and phenomenological methodologies. Ethnography is considered to fit particularly well given that one of its distinguishing features is that it demands a holistic and contextual understanding of behaviour, providing research techniques to facilitate the development of such an understanding. Furthermore, together with grounded theory, ethnography is understood to be an appropriate methodological framework for knowledge-building and theory generation as it involves hypothesis-generating inductive fieldwork (Swanson & Chapman, 1994).

In keeping with the case study approach, and given my concern with understanding contextual issues which mediated the provision of a comprehensive approach to care by the nurse participants, ethnography thus provided an appropriate theoretical approach for guiding this aspect of my research.

4.2.5.2 Ethnography

As a research approach, ethnography derives from cultural anthropology and refers to "any full or partial description of a group - *ethno* ('folk') and *graphy* (description)" (Boyle, 1994, p. 159). Central to ethnography is the study of culture (Patton, 1990) with the idea that any group that is together for a period of time will develop a culture. Culture is understood, inter alia, to refer to a shared system of meanings (Boyle, 1994). It follows therefore, that ethnography is centrally concerned with developing an understanding of these shared systems of meanings. Furthermore, although it was originally used in the study of small scale societies and groups who shared many similar social and cultural characteristics, it can be applied as *focused* ethnography to the study of any isolated group of people who have something in common (Boyle, 1994), such as professional groups or institutions as well as small scale health settings (Golander, 1992).

Ethnography is characterized by a number of features which include (i) its holistic and contextual nature; (ii) reflexivity; (iii) the use of emic and etic data; and (iv) its value in relation to the development of theory.

In the first instance, ethnography's *holistic and contextual nature* demands that all emergent data is interpreted within an understanding of the context within which observations and interviews take place. According to Hammersley et al. (1983):

> "any account of human behaviour requires that we understand the social meanings that inform it...The centrality of meaning also has the consequence that people's behaviour can only be understood in context" (p.9).

A contextual understanding of human behaviour therefore demands that the researcher moves beyond description to understanding why the behaviour

takes place and under what circumstances (Boyle, 1994). This requires that the interrelationships between the various systems and subsystems in the group being studied be made explicit.

The development of such an understanding has implications for the research techniques adopted. Ethnography requires that the researcher spends long periods of time observing the people being studied. This may either be continuous in which case the researcher may choose to become part of a group as a participant observer, or it may be noncontinuous consisting of short periods of intensive observation spread out over a long period of time (Boyle, 1994). Furthermore, ethnography comprises an in-depth understanding of one or two situations and generally adopts a multimethod approach in which a variety of other techniques such as interviews and document analysis are used (Bannister, Burman, Parker, Taylor & Tindall, 1994). Observation remains, however, the hallmark of ethnographic research.

> "It is a mistake to say you are doing ethnography and just do interviews. I think the idea is that it's a series of strategies, that whatever gets you the information, such as census reports, or asking the postmistress, or what have you. But if anything, it must include participant observation in some way" (Sandelowski, cited in Boyle, 1994, p. 158).

Secondly, *reflexivity* refers to recognition and reflection on the part of researchers of the role that they play in the research process, be it on the social phenomena under study or in the interpretation of the emergent data. According to Hammersley et al. (1983), there needs to be recognition that

> "we are part of the social world we study...There is no way in which we can escape the social world in order to study it; nor, fortunately, is it necessary. We cannot avoid relying on common sense knowledge nor, often, can we avoid having an effect on the social phenomena we study" (p. 7).

Thirdly, the use of *emic and etic* data refers to the insider's and outsider's perspectives of reality. The emic perspective refers to the insiders or participants view of what is happening and the etic perspective refers to the outsider's (researcher's) interpretation of this reality. Good ethnography makes use of both perspectives. Data is collected from the emic perspective of the participants and the researcher then tries to make sense of it from their etic perspective (Boyle, 1994). In this regard, the researcher brings to the research situation what Malinowski (cited in Hammersley et al., 1983) refers to as 'foreshadowed problems'. While the investigator in ethnographic research is more concerned with discovery than verification (Hammersley et al., 1983), the researcher normally commences the investigation with theory which according to Malinowski (cited in Hammersley et al., 1983) is not the same as 'preconceived ideas'. While acquaintance with theory and the latest literature on a subject provides for 'foreshadowed problems', the researcher needs to be informed by the emergent data, refuting or developing new hypotheses where necessary (Hammersley et al., 1983).

According to Werner and Schoepfle (1987), so long as the researcher is reflexive and aware of his/her role, an outsider is able, through interfacing with a culture through observation and interviews, to produce greater insights and understanding than may be possible by an insider alone.

Fourthly, ethnography is well placed to contribute to *theory development* as it is flexible. The research process is iterative in nature, thus demanding that the researcher change his/her research strategy in line with the developing theory.

> "Ideas can be quickly tried out and, if promising, followed up. In this way ethnography allows theory development to be pursued in a highly effective and economical manner"(Hammersley et al., 1983, p. 24).

They also suggest that the use of multiple methods of inquiry in ethnography, which forms the basis of triangulation, allows for data derived from different methods and sources tapping into the same issue, to be compared. This can be used as a validity check in theory development. Furthermore, the investigation of social processes in everyday settings as opposed to one which is contrived for research purposes is also considered to increase the validity of the theory developed as the danger that the findings will only apply to the research setting is lessened (Hammersley et al., 1983).

4.2.5.3. Case study setting

As discussed in Chapter One, this study emerged out of the work of the CMHP which had been involved in establishing a district mental health system in the KwaDedangendlale area of the Outer-west District of the Durban Functional Region. (cf. Petersen et al., 1996).

While the CMHP was an outreach programme of the Psychology Department at the University of Durban-Westville, it also operated under the umbrella of the Natal Institute of Community Health Education (NICHE), which was a partnership of academic institutions, service providers and the community in question. The aim of NICHE was to develop community-based health education and service programmes to promote comprehensive primary health care in the selected site. The CMHP's role within the NICHE programme was to develop a mental health care system at the primary level of care. At a structural level, the NICHE partnership model had facilitated the development of community health committees in the various tribal areas of KwaDedangendlale. The function of these health committees was to ensure community control over the health programmes at a local level. Furthermore, through these committees, the community was represented on the KwaDedangendlale Coordinating Committee, where all partners

participated in the overall development and coordination of the developing district health system.

The location of this study within the NICHE programme thus made access to the site and participants relatively easy. With regard to gaining formal permission to conduct the study, it was presented to, and approved by the coordinating committee. Furthermore, in order to gain the approval and participation of the primary health care nurses and psychiatric nurses servicing the sub-district, a meeting with them was set up by the coordinator of primary health care services for the region. This gave it further legitimacy as the study was seen to have the approval of the provincial health department.

Although developing an understanding of the setting forms part of an ethnographic study, a brief description of the site at this point is considered apposite in order to set the context for the focused ethnographic study. To begin with, although KwaDedangendlale is only 40-50kms from the city of Durban (see Figure 1, p. 3), it was considered a semi-rural area. Plate 1 (p. 105) provides a view of the semi-rural landscape of the area. Furthermore, traditional Zulu customs and cultural belief systems were still prevalent (Zulus are a Nguni people of southern Africa). While the population density was greater than in rural areas, houses were scattered and generally took the form of rondavels which are traditional round African homesteads, or square single storied structures. Plate 2 (p. 105) provides an example of a typical single storied square structure.

At the time of the study, KwaDedangendlale was divided into 5 tribal areas, KwaNgcolosi, Embo, Nyuswa, Qadi and Molweni (see Figure 1, p. 3). No exact or recent census data was available for the area, with the population estimates being based on an average figure for the number of people per household. Stavrou and Luckin (1992) estimated the population of the area to be 55 386

using an average figure of 7.4 per household, while Pitt (1994) arrived at an estimate of 72 938 based on a figure of 7.49 per household.

With respect to infrastructure, pit-latrines formed the most common form of sanitation; water was obtained from springs or taps on the roadside; candles and paraffin lamps were generally used for lighting; while wood, coal and gas stoves were used for cooking.

Regarding income levels, a significant proportion of the population were unemployed and lived below the poverty datum line. Most of those in formal employment worked in industries in Pinetown, a suburb of Metropolitan Durban, or even outside the province of KwaZulu-Natal, and came home only on week-ends or at the month-end. Economic activities in the area included some subsistence farming, as well as home-based activities such as running tuckshops or 'spazas', shebeens (small bars), or sewing garments and making beadwork to sell on the beachfront (Memela, Shembe, Bhagwanjee & Subedar, 1996).

With regard to health resources, KwaDedangendlale was probably better resourced than most other rural areas in KwaZulu-Natal. The formal health system centred around the Halley Stott Community Health Centre which provided a number of specialist services, as well as having a primary health care clinic which serviced the entire area. Plate 3 (p. 107) provides a view of part of the Halley Stott Community Health Centre. In addition, the tribal areas of Molweni and KwaNgcolosi both had fixed community clinics while the other three tribal areas, Embo, Nyuswa and Qadi were dependant on visits by a mobile clinic on a weekly basis. Plate 5 (p. 109) provides a view of the fixed community clinic in KwaNgcolosi. Plate 6 (p. 109) provides a view of one of the mobile clinic points, which often alternated with a crèche for pre-school children.

Plate 1: KwaDedangendlale Area

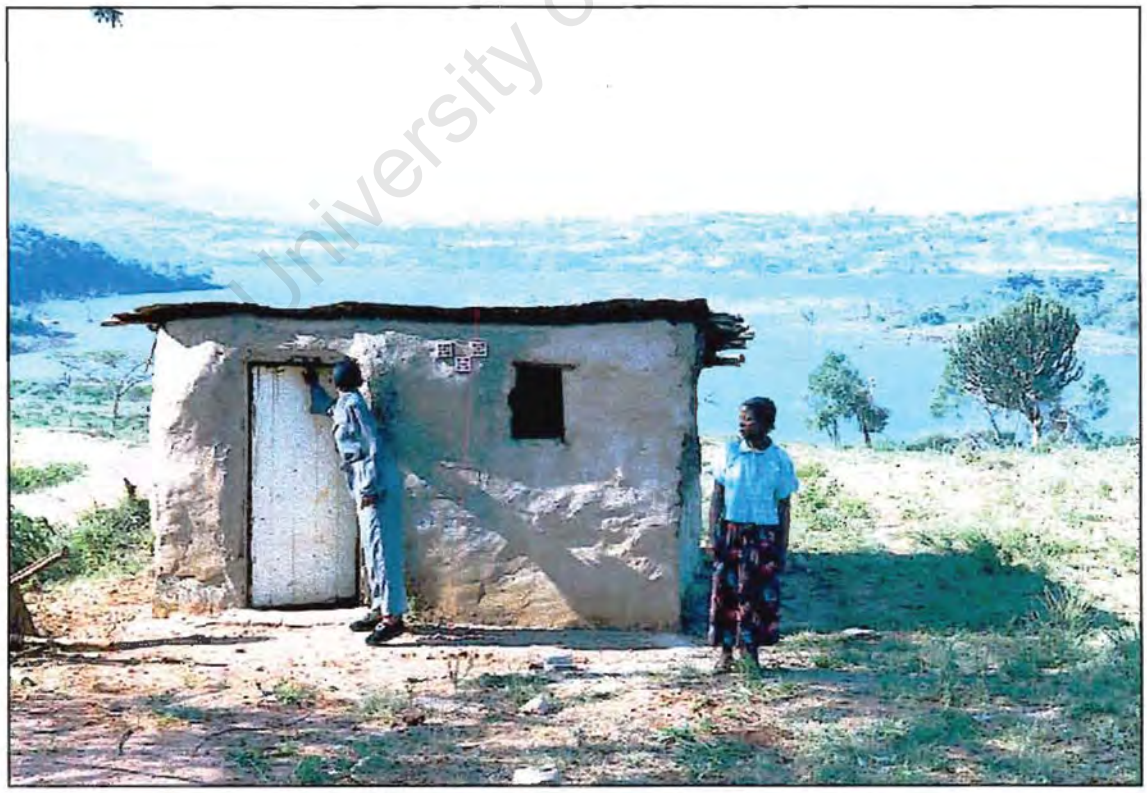

Plate 2: Example of a dwelling

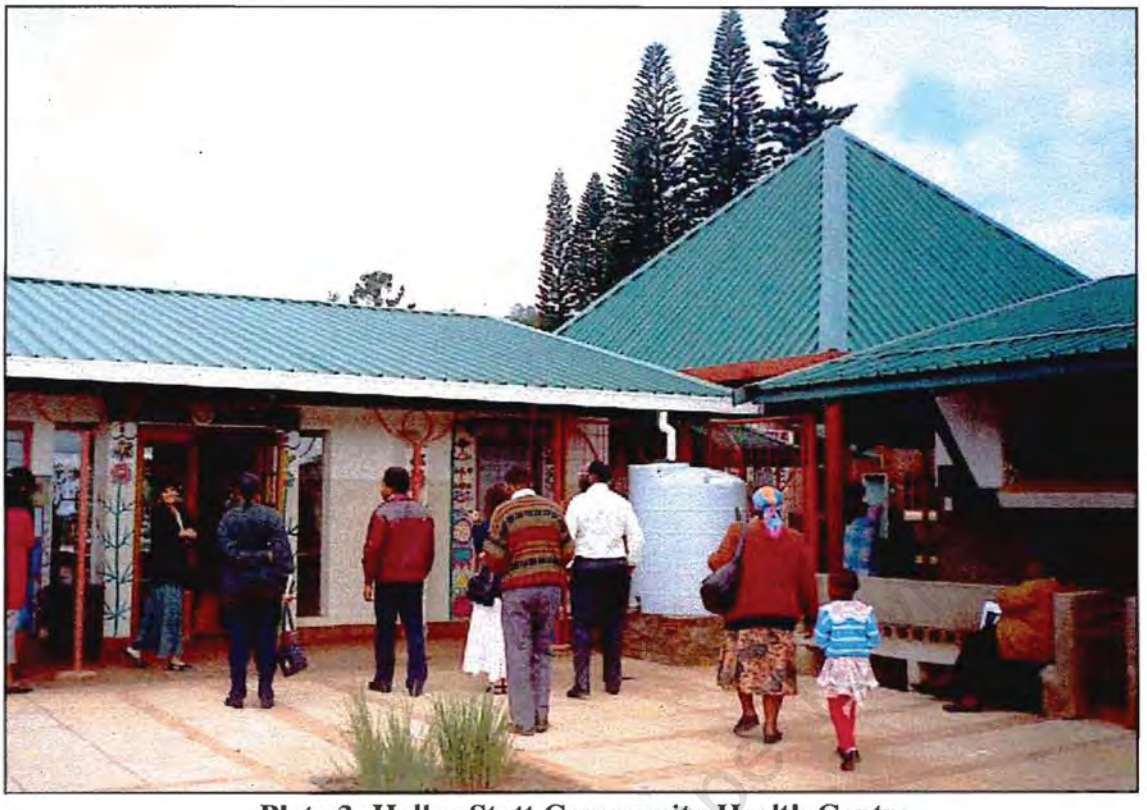

Plate 3: Halley Stott Community Health Centre

Plate 4: Clients waiting outside the Psychological Clinic

Plate 5: KwaNgcolosi Community Clinic

Plate 6: A mobile clinic

An outreach community psychiatric clinic run by psychiatric nurses attached to hospital psychiatric services from two hospitals in the Durban Functional Region operated from the community health care centre twice a month. The service provided largely repeat medication for psychiatric patients with serious mental illness.

Community outreach services were provided by community health workers in each tribal area, there being approximately 100 community health workers servicing KwaDedangendlale. One social worker based at the Halley Stott Community Health Centre provided social work services for all five tribal areas. In addition, there was a permanent AIDS counsellor at the community health centre and psychology interns, employed by the CMHP, provided a referral psychological service on a weekly basis. Plate 4 (p. 107) provides a view of clients waiting outside the psychological clinic to see the intern psychologist.

The primary health care nurses managed all the minor and most of the chronic illnesses seen at the primary level, and diagnosed and prescribed medication up to schedule 4, which precludes antibiotics and psychotropic medication, which are schedule 5 - 7 drugs, and which are required to be prescribed by a medical doctor. More serious cases requiring these medications, such as tuberculosis, were thus referred to the doctor based at the community health centre.

The traditional division of labour which operated in hospitals whereby doctors diagnose and prescribe and nurses observe and report thus did not function in this setting. In addition, the clinics were managed by the nursing services manager who was a matron. Although the doctor held power in terms of medical expertise, the power differential that characterises the relationship between nurses and doctors in hospital settings did not appear to operate to the same degree.

There were five primary health care nurses based at the Halley Stott Community Health Centre who saw on average fifty patients per day. Each nurse had her own consulting room and patients moved through three waiting rooms before they were seen by a nurse.

Two primary health care nurses assisted by nurse aides resourced the mobile clinics which were based at first-aid stations which often alternated with crèches. These first-aid stations generally comprised a waiting room, two consulting rooms and a kitchen. The labour was divided between two professional nurses, one who provided family planning and paediatric services and the other who provided adult consultations. The mobile clinics visited each tribal area only once a week and were consequently extremely busy. The waiting rooms, which were always filled to capacity, were separated from the consultation rooms by partitions. Noise levels were thus very high and a sense of privacy in the consultation sessions was difficult to attain. The two sisters saw all the patients who attended the clinics, approximately 70-80 patients each per day, between 10h00 and 16h00.

The fixed community clinics were also resourced by two primary health care nurses with the assistance of nurse aides. Although the nurse from the KwaNgcolosi Clinic reported that they saw between 75-80 cases a day, the clinics did not, on observation, appear to be very busy, with the queues being relatively small.

Based on clinic records, the distribution of the different types of treatment provided by the health services in the KwaDedangendlale area during 1992/3 is contained in Figure 2 (p. 113). As discussed, the psychiatric service was concerned primarily with the provision of follow-up care for the seriously mentally ill. Psychiatric care for common mental health problems was thus not provided. Furthermore, given the association between common mental health problems and minor physical ailments (e.g., Harding et al., 1980;

Patel, 1998; Swartz, 1998), these problems were likely to occur most frequently (50.3%) within the general treatment category. Moreover, in view of a recent community-based epidemiological study of anxiety and depressive disorders in the KwaDedangendlale area, which revealed a prevalence rate of 24.9% for adults (Bhagwanjee et al., 1998), roughly 25% of this general treatment category were thus likely to be suffering from a common mental illness.

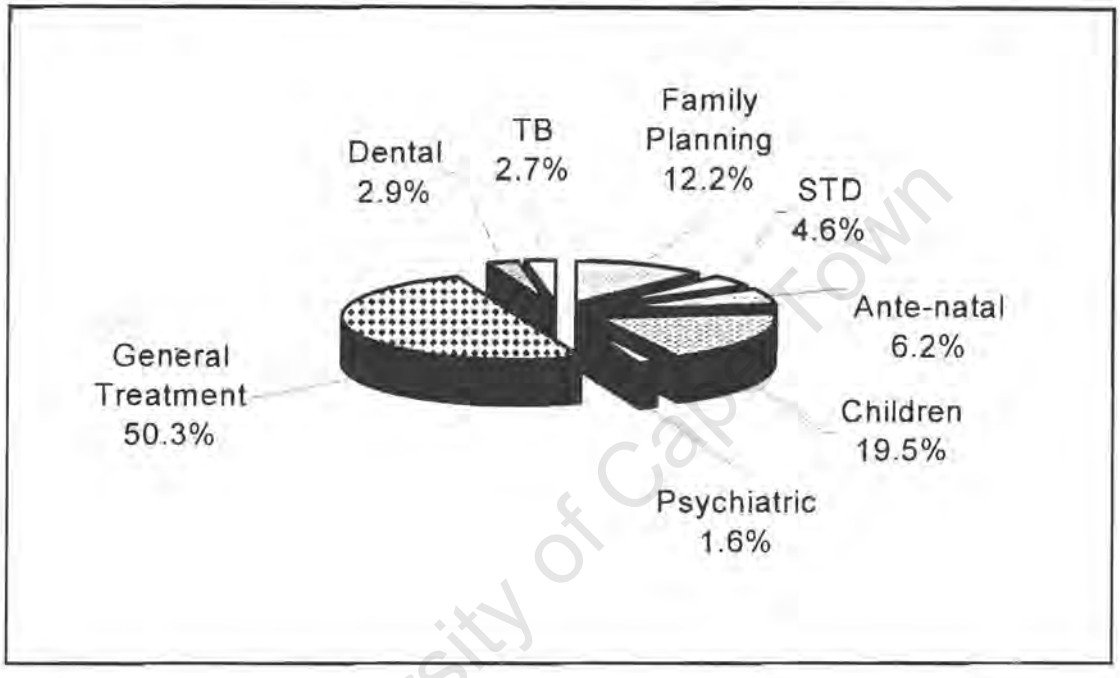

Figure 2: Pie chart of different types of treatment provided by the health services in KwaDedangendlale during 1992/3. (Source: Lambert cited in Memela et al., 1996)

While the KwaDedangendlale area formed the broader setting of the case study, the primary health care clinics in this area formed the settings for the focused ethnographic investigation. Given that this study was concerned with establishing the factors which mediated the capacity of nurses to provide comprehensive care following the reorientation and training programme, the participants on the programme were obviously targeted for observation and interviewing. Furthermore, given the need to understand behaviour contextually, observation of the functioning of the clinics where they worked was also important.

4.2.5.4 Participants

In view of the need to ensure that the health care service was not interrupted by the study, the nursing services manager ruled, in the first instance, that only primary health care nurses who did not have any previous psychiatric training were allowed to participate in the study. Secondly, given that there were only two professional nurses located in the fixed community clinics, only one from each clinic was allowed to attend the reorientation and training programme. Although the mobile clinic service was run by two professional nurses, they were, however, both allowed to participate as the mobile service did not operate on a Friday, when the programme was run. In addition, given that there were five professional nurses servicing the clinic at the community health centre, two were relieved of their duties on a Friday to enable them to participate. All the PHC nurse participants were middle-aged women of the Zulu Nguni people of South Africa.

In addition to the primary health care nurse participants, four psychiatric nurses who resourced the outreach psychiatric service to the area attended the reorientation and training programme, and thus also formed part of the study. These psychiatric nurses were not part of the district health team but were attached to the hospital psychiatric services of two hospitals in the province of KwaZulu-Natal (King George V Hospital and Prince Mshiyeni Hospital). These hospital psychiatric services provided an outreach community psychiatric clinic service to various outlying areas, with the KwaDedangendlale area being one of those serviced.

The four psychiatric nurses who participated on the reorientation and training programme were chosen by the nursing services manager in charge of the community psychiatric services for the region on the basis of their involvement in the provision of community psychiatric services to the KwaDedangendlale area. The motivation for their participation was based

on the need for them to be updated and to learn how to run a similar reorientation and training programme for primary health care nurses in other areas that they serviced.

In relation to observations of nurse patient consultations, only adult consultations were used for this study, yielding a total of eighty observed nurse-patient consultations, forty being from the pre-assessment and forty from the post assessment. The gender breakdown of the observed patients was 23.75% males and 76.25% females. The large number of female patients compared to male patients reflects the gender bias of 3.5:1 (females to males) found by the epidemiological study on common mental disorders in the area (cf. Bhagwanjee et al., 1998). This gender bias is probably reflective of the fact that the clinics are only open during the day, a time when most men who are employed, are likely to be at work. A breakdown of the presenting complaints of the observed patients is contained in Figure 3, below.

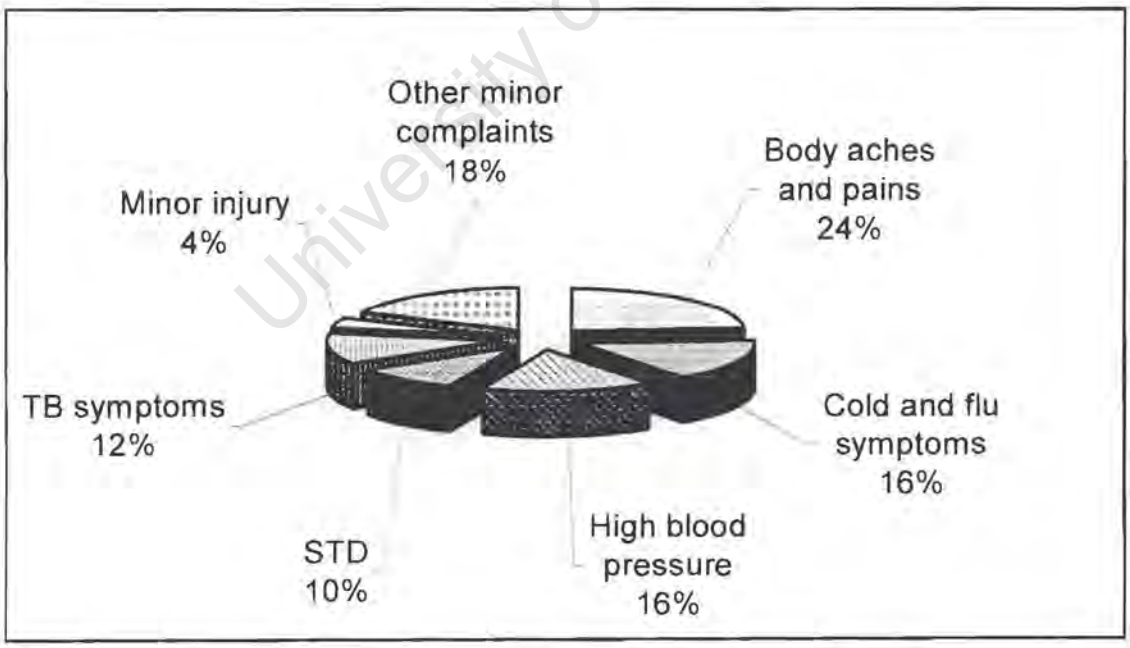

Figure 3: Pie chart of presenting complaints of patients in the observed nurse-patient consultations

Given the iterative nature of qualitative inquiry, in order to follow-up on hypotheses generated by interviews and observations of the nurse participants, a number of other interviews were also held. These included interviews with some of the patients suspected of having mental health problems. A total of ten patients were interviewed. Furthermore, interviews with key informants were also conducted. These included the nursing services manager of the Halley Stott Community Health Centre; the coordinator for primary health care services in the Durban Functional Region; and a black African psychologist whose internship placement had been with the CMHP, which had involved, inter alia, providing a psychological service at the Halley Stott Community Health Centre.

4.2.5.5 Data collection techniques

Data collection techniques involved the use of observation and tape recording of nurse-patient consultations; observation of clinic activities; unstructured individual interviews; and focus group interviews.

Observation

> "The purpose of observational data is to describe the setting that was observed, the activities that took place in that setting, the people who participated in those activities, and the meanings of what was observed from the perspective of those observed." (Patton, 1990, p. 202).

I used participant observation techniques in this study to develop an understanding of the care provided by the nurse participants both before and after the reorientation and training programme with the view to understanding how the clinic setting and functioning mediated their capacity to provide comprehensive care.

According to Patton (1990), direct observation of programme implementation has several advantages. In the first instance, it provides the evaluator with an understanding of the context which is essential for the development of a comprehensive understanding and interpretation of the programme being evaluated. Secondly, it facilitates an inductive approach to discovery as it is heavily reliant on first-hand information, as opposed to second hand explanations. Thirdly, it allows the evaluator to see things which may escape the conscious awareness of the participants. Finally, it provides the opportunity for the evaluator to discover unconscious issues that participants may deny or issues that they may be unwilling to talk about in an interview, thus permitting the evaluator to move beyond the selective perceptions of others.

According to Silverman (1993), participant observation varies along the continuum from 'complete participation' to 'complete observer' and from covert to overt observations depending on the role that the researcher plays in the context. In this study, the level of my involvement varied depending on the context. Given my role in developing the mental health services in the area, I attended meetings etc., where I acted as a 'complete participant'. In these contexts my observations were also partially covert, as although the participants were aware that I was conducting this study, I did not announce at every meeting that I was going to act as a participant observer. On the other hand, when observing clinic activities and particularly the nurse-patient consultations, I functioned more towards the 'complete observer' end of the continuum. In this context there was full disclosure about the fact that my research assistant and myself were observing for evaluation purposes and consent from both the nurse participants and patients was obtained.

My involvement in the field stretched over a total of three years, from 1996 to 1998. During this period I kept a research journal in which I recorded my

observations of clinic activities, issues that arose at meetings as well as insights and hypotheses that I wanted to investigate further.

In relation to the actual evaluation of nursing care, I initially observed and audiotaped nurse-patient consultations prior to the reorientation and training programme. My observations of each nurse participant's consultations with patients lasted for 1½ - 2 hours. Given my limited understanding of the Zulu language, I was accompanied by my research assistant, an honours psychology student who was employed by the CMHP, who was Zulu speaking, and who acted as an interpreter for me. While I could not always understand what was being said in the nurse-patient consultations, I took field notes on my observations. These field notes contributed to my data and I analyzed them together with the transcripts of the consultation sessions, which were interpreted and transcribed by my research assistant.

To allow consolidation of the skills acquired, the post programme evaluation occurred six months after the reorientation and training programme had been completed, although during this period I provided a consultancy service to the nurse participants in the form of consultation sessions on a monthly basis. In the post programme evaluation, I again observed and audiotaped the nurse participants' consultations with patients for 1½ - 2 hours each.

Interviews

> "The purpose of interviewing is to find out what is in and on someone else's mind. The purpose of open-ended interviewing is not to put things in someone's mind (for example, the interviewer's preconceived categories for organizing the world) but to access the perspective of the person being interviewed. We interview people to find out from them those things we cannot directly observe... The fact of the matter is that we cannot observe everything. We cannot observe feelings, thoughts, and intentions... Qualitative interviewing begins with

> the assumption that the perspective of others is meaningful, knowable, and able to be made explicit". (Patton, 1990, p. 278).

The hallmark of ethnographic interviewing is that it needs to be reflexive (Hammersley et al., 1983). Although interviewers may have a list of issues that they wish to cover in the interview, reflexivity demands that the interviewer actively listens to what the interviewee is saying and uses it to shape the rest of the interview.

Although English was a second language for most of the participants, with the exception of the patients interviewed, they were all relatively fluent in English, so that language did not present itself as a problem for interviews with the nurses and key informants. Patients were interviewed by my research assistant, who was a Zulu speaker. Given that she was an employee of the CMHP, she assisted me throughout the study and was also involved in the actual reorientation and training programme. As such, she had a good knowledge of the goals of the programme and what information to probe for in her interviews with the patients.

I used the interview guide approach to interviewing. This approach involves developing a set of issues that one wishes to explore with each respondent. This serves as a basic checklist to ensure that all the relevant topics are covered during the interview. The interviewer then explores, probes and asks questions around these topics in an unstructured manner (Patton, 1990). The advantage of this approach is that it ensures that interviewing across a number of different people is done in a systematic way but it does not exclude other topics emerging which are of importance to the respondent (Patton, 1990) (see Appendix 3 for an example of the interview guide which I used with the primary health care nurses).

Individual interviews were held with all the primary health care nurse participants (six) prior to the reorientation and training programme as well

as following the programme (six). I used these interviews to assess whether there had been a change in their perceptions of the care that they provided as well as to assess any difficulties that they had with the concept of comprehensive care as well as its implementation.

Individual interviews were also held with patients (five) prior to the programme as well as following the programme (five). Only patients suspected of having a psychological/psychosocial problem and who were observed in the consultation sessions with the nurses, were interviewed. The purpose of these interviews was to gain insight into how the patients perceived their problems and how they perceived the consultations with the nurses.

Focus group interviews are interviews with a small homogeneous group of people, typically 6 - 10. In relation to size, the conditions are that they should be small enough for all the participants to have the opportunity to share insights and large enough to allow for a diverse pool of ideas to emerge (Krueger, 1994).

The advantages of focus group interviews over individual interviews lie in their social nature. According to Krueger (1994), people are social creatures, and hence influenced by group processes. Data on perceptions and opinions may therefore be enriched through group interaction as inhibitions are often relaxed in a group situation, thus encouraging increased candour on the part of respondents (Carey, 1994; Krueger, 1994).

According to Patton (1990), one of the advantages of focus group interviews for evaluation studies is that they provide for some quality controls on data collection. In this regard, participants normally provide checks and balances on one another, weeding out false or extreme views and allowing for an assessment of whether there is a relatively consistently shared view of the programme by the participants.

In this study I used focus group interviews at the beginning of the reorientation programme as well as during the consultation sessions following the programme. The participants included the primary health care nurse participants (six) as well as the psychiatric nurse participants (four), although their attendance varied in the consultation sessions. I used the focus group interviews to acquire information largely on the problems that they experienced in trying to implement a comprehensive approach to care.

In order to follow-up hypotheses about factors which mediated the implementation of a comprehensive approach to care I also interviewed the three key informants described in section 4.2.3.4, who I thought would be able to throw some light on these issues. This is in line with the iterative nature of qualitative research as well as Glaser and Strauss's (1967) concept of 'theoretical sampling'. This concept suggests that who is interviewed, and when and how, is dependent on what the research process generates in terms of one's current state of knowledge, and one's judgment as to how this knowledge may be developed further.

4.2.5.6 Ethical considerations

While ethical principles may differ across cultures, the basic theme in Western bioethics concerns respect for people. As I mentioned earlier, my involvement as a researcher stretched from partially covert complete participant observer to overt complete observer. I suggest that my participation in some aspects of observation was partially covert in that, although the participants had prior knowledge that I was conducting the study and had agreed to it, I did not ask for permission to play the role of participant observer at every meeting. Furthermore, according to Lipson (1994), anonymous observation is ethically appropriate and defensible in public situations open to everyone, such as clinics.

With regard to very personal situations which involved nurse-patient consultations, my role as researcher and observer was made very clear and informed consent was obtained through a written contract from both the nurse participant and patient concerned. I have included copies of these contracts in Appendices 4 and 5.

Other ethical considerations pertinent to this study involved the issue of reciprocity. My position on this issue is that it is unethical to conduct research in communities if they do not benefit from the research. The benefits to the community from this study included firstly, capacity development of the primary health care nurses with regard to mental health care. Secondly, this study was linked to a larger project aimed at the development of a district mental health system in the identified area. Thirdly, the evaluation component was conducted with the express purpose of understanding the factors which mediated the nurse participants' capacity to provide comprehensive care. Furthermore, this information was fed back to the participants via the nursing services manager in the hope that some of the issues raised by the research process would be addressed.

4.2.5.7 Data analysis

Morse (1994) suggests that there are four cognitive processes which are common to all qualitative methods, namely, comprehension, synthesizing, theorizing and recontextualizing. *Comprehension* involves learning everything about a setting or the experiences of the participants and should involve what Geertz (1973) termed 'thick description'. This refers to solid descriptive data which forms the basis for interpretation and which enables others reading it to assess your interpretations and make their own accordingly. A second aspect of comprehension is coding of the data which "helps the researcher sort the data and uncover underlying meanings in the text and metaphorical references, and brings both the central and peripheral

referents to the researcher's attention" (Morse, 1994, p. 29). These codes may then be compiled into categories.

Synthesis involves comparative analysis across participants and settings. It facilitates the establishment of patterns and variations. According to Morse:

> "Potential generalizations first are discovered in one case, and then this case is compared with another similar case, and another, and this process is repeated until the phenomena identified can be tested against all similar cases" (Morse, 1994, p. 31).

Theorizing involves giving meaning to the emergent data. According to Morse (1994):

> "(it) is the systematic selection and 'fitting' of alternative models to the data...(it)...is the process of constructing alternative explanations and of holding these against the data until the best fit that explains the data most simply is obtained" (p. 33).

The development of theory involves both inductive and abductive analysis. Inductive analysis as promoted by Glaser et al. (1967), in their development of the concept of grounded theory, demands that the researcher approach the analysis of the data free of any theoretical notions and preconceptions. According to them "an effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated" (Glaser et al., 1967, p. 37). This concept of inductive analysis has been challenged on the basis that the process of discovery is influenced by existing knowledge and understanding which may be modified/challenged by new findings (e.g., Kelle, 1993).

The aim of hypothetical reasoning, is to find a hypothesis, which can explain certain findings. According to Kelle (1993), hypothetical reasoning is based on two forms of logical inference, qualitative induction and abduction.

> "By qualitative induction a specific empirical phenomenon is described or explained by subsuming it under an already existing category or scientific law. After having entered the empirical field the researcher observes a phenomenon, which he can explain on the basis of his previous knowledge. The paradigm for qualitative induction is the "diagnosis" in medicine or clinical psychology... qualitative induction helps to explain a certain event by subsuming it under an already existing concept or rule, abductive inferences serves to discover new, hitherto unknown concepts or rules. Thereby the starting point of an abductive inference is a surprising, anomalous event, which cannot be explained on the basis of previous knowledge" (Kelle, 1993, pp.7-8).

Abductive analysis requires the revision of previously held preconceptions or theories. In this sense the researcher is therefore always dependent on his/her previous knowledge which provides the framework for interpretation of the phenomenon under investigation.

Recontextualizing refers to the generalisation and recontextualization of the developed theory to other settings.

An outline of the process of analysis used in this study

I began my analysis of the data by initially focusing on my observations and transcriptions of the nurse-patient consultations from both before and after the training and reorientation programme, with the view to comparing whether there had been a shift in the actual care provided. Given the quantity of data (eighty consultations in total), I used The Ethnograph v4.0, a qualitative software package (cf. Seidel, Friese & Leonard, 1995), to assist me in my analysis of this data.

At the comprehension stage, I first identified first-level codes which I grouped into categories. The Ethnograph programme also provided me with the facility for recording memos on insights that I had at this stage of the data analysis process, thus facilitating the development of theory from an early stage. Synthesis involved a comparison of the emergent categories across the participants which was also facilitated by The Ethnograph programme, resulting in the emergence of typologies. According to Lofland (cited in Hammersley et al., 1983), the identification of typologies of strategies for example, involves (i) the collection of information on how a problem is dealt with by the people being studied; (ii) teasing out the variations; (iii) classifying them into types of strategies; and (iv) finally presenting them in an orderly fashion to the reader.

An example of how I developed typologies in my analysis is illustrated by the development of my understanding of how the nurse participants dealt with overt psychosocial problems prior to the reorientation and training programme. In this regard, I initially coded the transcripts according to whether psychological problems were overtly present. I also coded the transcripts according to the intervention provided in terms of whether it was purely biomedical or whether it included counselling or advice. Furthermore, I coded the transcripts according to whether the nurses ignored overt psychological problems. I then combined these codes to form categories which consisted of either ignoring the problem and providing purely biomedical care or giving advice, which I found to be associated with a paternalistic or authoritarian attitude (which was also coded). Looking for patterns, I found these strategies characterised the care provided in these cases across the nurse-participants. Hence my typology of nursing care emerged, which suggests that, in the face of overt psychological/psychosocial problems, nurses either rendered these problems 'invisible', providing only biomedical care, or as a result of the power invested in nurses and reflected in their paternalistic and/or authoritarian attitudes towards patients, resorted to 'coercion'.

Theorising involved, in the first instance, trying to understand these emergent typologies and variations using my understanding of the context, existing theories, and the individual and focus group interviews with the nurse participants. Furthermore, following the concept of theoretical sampling, I engaged in interviews with key informants to test out my hypotheses.

As a result of this process, I developed my understanding of the factors which mediated the provision of comprehensive care by the nurse participants. With respect to the above illustration, I found for example, that lack of skills was one issue that accounted for the identified strategies for dealing with overt psychosocial problems. Other issues also played a role. In this regard, I found that only one nurse in the post-assessment continued to render overt psychosocial/psychological problems invisible. Following the process of theory development, I tried to understand this variation in the data further, using my interview with this particular nurse in the post assessment, my understanding of the context, as well as my reading of the literature as tools in this process.

In relation to the presentation of my findings, I have organised my interpretations of the factors mediating the capacity of the nurse participants to provide comprehensive care thematically, providing detailed excerpts from the original data to back-up my interpretations.

4.3 Second phase

4.3.1 Research design

Qualitative ethnographic inquiry also informed the second phase of the study which was concerned with developing an understanding of issues impeding the transformation of the health care system to being supportive of comprehensive care. This phase emerged out of the findings of the first phase which indicated that the structure and organization of health care played a

significant role in mediating the capacity of the nurse participants to provide comprehensive care.

I held individual and focus group interviews with key informants from district level through to national level within the health care system with the view to tapping participants' understandings of how the integration process was viewed from the perspective of management as well as specialist psychiatric personnel. As such, this aspect of the study was less bounded by the case study site. Ultimately, however, the interviews were conducted with the purpose of developing a greater understanding of the factors mediating the capacity of the primary health care nurse participants to provide comprehensive care.

Using unstructured interviews, I interviewed a vertical cross-section of key individuals in management positions at district, regional, provincial and national levels. In total eleven managers, eight from within the province of KwaZulu-Natal and three at a national level were interviewed. In order to retain anonymity the positions of the participants have not been disclosed. However, they comprised three senior managers at national level; two senior managers at provincial level; four managers at regional level; and two managers at district level.

In addition, I also held three focus group interviews with psychiatric nurses who attended a summer and winter school in 1999 on district mental health systems development. These psychiatric nurses had been identified by the provincial mental health coordinator as needing to develop skills in developing district-based systems of mental health care, but had not all been officially allocated the responsibility of developing mental health systems within their districts. There were 11 participants in the focus group derived from the summer school. Two focus groups of 11 participants each were derived from the winter school. In the first focus group, there were representatives from four of the health regions in the province of KwaZulu-

Natal, while there were representatives from all the regions in the second two focus groups. All groups were relatively equally mixed according to gender and comprised predominately black African participants, although a few Indian and white participants were also present.

The individual and focus group interviews focused on tapping perceived barriers to the integration process. More specifically, participants were asked about barriers that existed at the level of the individual; within the organizational structure of the health care system; and within the broader macro context. Interviews were transcribed and analyzed using the process of inductive and abductive analysis described previously.

4.4 Conclusion

In this chapter I have provided an overview of the development and implementation of the reorientation programme which constituted my first objective. Furthermore, I have motivated for and outlined the research methods used to evaluate this programme and to ascertain the factors mediating the capacity of the nurse participants to provide comprehensive care, which constituted my second and third objectives of the first phase. Moreover, I have also outlined the research design for the second phase, which emerged out of the findings of the first phase, and was concerned with developing an understanding of how to transform the health care system to one which would be supportive of a comprehensive discourse of care.

Following Malinowski's (cited in Hammersley et al., 1983) concept of 'foreshadowed problems', the analysis of my data was informed by theory on organizational transformation as well as the context of nursing in South Africa. In the following chapter (Chapter Five), I therefore discuss a conceptual framework of organizational change which guided my interpretations, as well as provide an overview of nursing in South Africa which provided the context for the interpretation of the data.

CHAPTER 5

'FORESHADOWED PROBLEMS': A CONCEPTUAL FRAMEWORK FOR THE ANALYSIS OF THE EMERGENT DATA AND A CONTEXTUAL ANALYSIS OF NURSING IN SOUTH AFRICA

5.1 Introduction

In this chapter I discuss the conceptual framework which informed my analysis of the data for the qualitative aspects of the study. Furthermore, I have provided an overview of the history and status of the nursing system in South Africa, which provides the context for the analysis of the emergent data.

With regard to the conceptual framework, while critical and cultural approaches within medical anthropology literature provide a critique of biomedicine, the emphasis has, however, been on describing and analysing the relationship between the clinician and the patient, with very little attention being given to the context within which this relationship occurs (Sankar, 1988). In relation to this, Good and Good (1993) raise the need for the relationship between medical knowledge (and practice) and the nature of medical institutions (including their social and economic organization, as well as the nature of power relations and social hierarchies) to be made explicit.

In view of the need for such a contextual understanding, together with the overall aim of this study, which was to develop an understanding of how to effect a shift towards a comprehensive discourse of care, I chose to analyze the emergent data from within a framework of organizational change. More specifically, I chose to adopt the model of organizational change developed by the Tavistock Clinic (Obholzer & Zagier Roberts, 1994) as a guiding

framework for the analysis of the emergent data. My reasons for choosing this model were twofold.

In the first instance, this model adopts open systems theory which understands organizations as comprising a social system and a technical system located within a broader macro-context. A systems perspective is adopted by most theories of organizational change (e.g., French & Bell, 1995; Scott, 1998). Such a perspective is important in order to consider the inter-relationship between various aspects of an organization as well as the impact of macro-environmental issues on the functioning of the organization. The need to consider the inter-relationship between the different levels of an organization is emphasized by Menzies Lyth (1991) who suggests that intervention cannot occur at only one level within a system. She used her work with nurses to illustrate this need, suggesting that programmes designed to increase nurses' sensitivity to their clients and to themselves without paying attention to the organization of nursing care will not be successful. To quote:

> "But they usually return to a work situation where roles and structure have not been modified. This may make it impossible for them to deploy their new insights in action. A nurse cannot be more sensitive and intimately related to her patients when a nursing system based on multiple indiscriminate caretaking prevents her from ever really getting to know them well" (Menzies Lyth, 1991, p. 371).

Secondly, unique to the Tavistock model is its emphasis on understanding institutions using psychoanalytic concepts. This involves bringing to institutional understanding, ideas developed in the context of individual therapy, which includes looking at institutions in terms of unconscious emotional processes (Halton, 1994). Understanding organizations from this perspective thus involves bringing psychoanalytic understandings to the analysis of work culture, role analysis and structural analysis (Menzies Lyth, 1991).

In this chapter I initially provide a summary of some key contributions from psychoanalysis to understanding organizational life which provides the *conceptual* framework used to analyze the emergent data. This is followed by an overview of the dynamics of the nursing system in South Africa which provides the *context* for the analysis of the emergent data.

5.2 Unconscious aspects of organizational life

As with individuals, organizations are understood to develop defences against anxieties generated by the work context. While some institutional defences are healthy in that they enable staff to cope with the stressors entailed in their work, others are unhealthy, impeding work activities and adaptation to changing circumstances (Halton, 1994).

Defences commonly found in organizations include denial, splitting and projection. Denial involves pushing anxiety-provoking thoughts, feelings and experiences out of conscious awareness. Splitting involves the differentiation of feelings into good and bad components in order to obtain relief from internal conflicts. Splitting is often accompanied by projection which involves locating negative feelings in others rather than oneself in order to retain a sense of self idealization. While projective identification remains one of the least well defined concepts within psychoanalytic thinking (Ogden, 1982), I have interpreted it, in this thesis, to refer loosely to taking on these projected feelings and experiencing them as if they were your own. To quote Ogden (1982):

> "Projective identification is a concept that addresses the way in which feeling states corresponding to the unconscious fantasies of one person (the projector) are engendered in and processed by another person (the recipient), that is, the way in which one person makes use of another person to experience and contain an aspect of himself. The projector has the primarily unconscious

> fantasy of getting rid of an unwanted or endangered part of himself (including internal objects) and of depositing that part in another person in a powerfully controlling way. The projected part of the self is felt to be partially lost and to be inhabiting the other person. In association with this unconscious projective fantasy there is an interpersonal interaction by means of which the recipient is pressured to think, feel, and behave in a manner congruent with the ejected feelings and the self- and object-representations embodied in the projective fantasy. In other words, the recipient is pressured to engage in an identification with a specific, disowned aspect of the projector" (pp. 1-2).

The paranoid schizoid position which involves schizoid splitting, where parts of the self, perceived as bad, are split off and projected outwards, characterizes early childhood. According to Klein (cited by Halton, 1994) this is a normal stage of development, but can recur throughout life. Furthermore, it has been found to be useful in understanding organizational life from a psychoanalytic perspective. In this regard, it commonly occurs in relation to client groups and between groups within an institution, such as between departments or professions. The less contact there is between the different groupings, the more scope there is for projection, and contact may be avoided unconsciously to perpetuate self-idealization based on these projections (Halton, 1994).

Many of these defences come into play when an institution fails to contain the anxieties generated by the work context. The concept of 'containment' within organizational work was developed by Bion (1967) and has its roots in the mother-infant relationship where a 'containing' mother is able to contain an infant's anxieties in such a way that they become bearable. Similarly, in work contexts which are anxiety provoking, containing organizations are able to contain these anxieties and facilitate a shift to a position where schizoid splitting and denial of reality are not necessary, and a position of integration and co-operation is possible. The latter position is referred to as the 'depressive' position and is understood to promote co-operation within organizations. To quote Halton (1994):

> "The group will be more able to encompass the emotional complexity of the work in which they all share, and no one member will be left to carry his or her fragment in isolation... this involves being aware of the particular stresses involved in their work, as well as recognizing its limitations" (p. 18).

In relation to the issue of containment, Stokes (1994) suggests that the sub-culture of an organisation also gives rise to a particular complex of feelings, thoughts and behaviours which often play an anxiety containing role, particularly in human service organisations. Resistance to change can thus be expected unless these issues are adequately addressed. This understanding is based on the work of Wilfred Bion (1961) who suggested that there were two main mentalities which dominate work behaviour: (i) a work-group mentality where members are intent on carrying out a specific task and wish to assess their effectiveness in doing it; and (ii) a basic assumption mentality, which is often unconscious, and where there is a tendency to avoid work on the primary task because it is anxiety provoking. He distinguishes three basic assumptions: (i) basic assumption dependency; (ii) basic assumption fight-flight; and (iii) basic assumption pairing. The first is particularly pertinent to understanding nursing sub-culture as it is characterised by a resistance to change and a pre-occupation with bureaucracy, status and hierarchy which gives rise to a culture of subordination.

5.3 The nursing system in South Africa

5.3.1 History of nursing in South Africa

According to Myburgh and Owen (1990), biomedicine has historically underpinned the training of health care practitioners in South Africa, including nurses. Furthermore, of special concern is that, although nurses form the back-bone of the primary health care system in South Africa, their

training has not adequately equipped them with the necessary orientation or skills to meet the needs of comprehensive primary health care (Strasser, 1999). In the first instance, their theoretical training has relied heavily on rote learning which encourages conformity as opposed to critical autonomous thinking required for the delivery of primary health care (Marks, 1994), with little critique of social oppression or the social control function of biomedicine.

Secondly, their practical training has historically been largely hospital based, with an emphasis on biomedical care. Furthermore, according to Edelstein (1996), training in tertiary academic centres has taught nurses to take instructions from doctors. It has not, therefore, engendered in nurses the necessary skills to work autonomously, which is necessary in primary health care settings, nor to understand illness as a social, cultural, biological and psychological construct.

In order to facilitate a shift towards a comprehensive discourse of care, I suggested (in Chapter Three) that the dominant biomedical attitudes and behaviours of primary health care providers, particularly medical practitioners and nurses, would need to be challenged. Given the scientific and ideological basis of biomedicine, this would entail creating a critical awareness of the role played by biomedical ideology in shaping their consciousness. As been shown, medical practitioners focus on the disease aspects of illness and ignore emotional and associated illness problems (e.g., Mischler, 1984; Waitzkin, 1991).

Furthermore, while nursing theory is based on holism understood to encompass the physical, psychological, social and spiritual aspects of the person (Holden, 1990), a number of studies have demonstrated a disparity between nursing theory and nursing practice, which has been found to be biomedical and task oriented (Littlewood, 1989; May, 1995). According to Sarter (1987), holism emerged out of the professionalization of nursing in an

attempt to establish nursing as a profession of equal but separate status to medicine (Sarter, 1987). To quote:

> "They are forming a counter-model where the stress is on a holistic perspective and where the knowledge of the patient's illness and experience is central" (Samualson, 1991, p. 200).

The disparity between nursing practice and nursing theory has been attributed to the hegemony of biomedicine, and fueled by the subordinate position of nursing in relation to medicine.

With regard to the subordination of nursing by medicine, nurses have historically been treated as assistants to doctors, a position compounded by gender relations in a patriarchal society in which women play a subservient role to men. The medical profession, dominated by men, exploited patriarchal ideology to entrench the power and control of medicine, with "sub-ordination (becoming) the hallmark of a medically defined good nurse" (Gamarnikow, 1991, p. 124).

Women were seen to be uniquely qualified to be nurses in view of their 'natural female condition' as they would provide support to doctors and execute orders without questioning the medical practitioners point of view. This sub-ordinate position was reinforced by Florence Nightingale and the Anglican sisterhood whose conception of a nurse was to function "in a triple role of wifely obedience to the physician, motherly care towards the patient, and household manager in relation to the auxiliary staff" (Rispel et al., 1991, pp.110-111).

The sub-ordinate position of nursing in relation to medicine, often played out at an individual level by a subservient attitude towards medical doctors, thus needs to be challenged. The same applies to the supplanting of a 'nursing gaze' or holistic approach to care by a 'clinical gaze', a term coined by Foucault

(1973), to refer to the biomedical approach to patient care. From a systems perspective, this cannot, however, be achieved in isolation from addressing issues inherent in other aspects of the system which operate to support the hegemony of biomedicine.

Thus, although nurses have a body of theoretical knowledge emphasizing holistic care, their domination by the medical profession in the health care system precludes them from exercising control over their practice. Although the professionalization of nursing was an attempt by nursing to establish itself as a profession of equal but separate status to biomedicine, it has not been successful at implementing its own theories of health care, nor at altering the monopoly of the medical profession in the health care system (Rispel et al., 1991).

In fact, Marks (1994) suggests that professionalization of nursing in South Africa (visible in an increase in the number of years of training of the general registered nurse from three to four years in 1986, as well as the obligatory association of colleges of nursing with university nursing departments in the same year) has served to increase the distance between nurse and patient through increasing the status of the nurse. To quote:

> "The deeply entrenched ideology of professionalism and the emphasis on status, as well as middle-class aspirations of the fully trained nurses, frequently create a gulf between them and their patients - as well as between them and enrolled staff' (Marks, 1994, p. 208).

In this way nursing has also become more closely aligned with biomedicine given the class origins and social status of medical practitioners who have historically been drawn from middle class families (Waitzkin, 1991). Furthermore, according to Waitzkin (1991), an acquired class position resulting from entering the medical profession, does not encourage medical

practitioners, coming from a working class background, to question the social structural roots of distress. The same could probably be said of nurses who have achieved an 'acquired status' as a result of entering the nursing profession. Moreover, the importance of status in the nursing profession is visible in the internal hierarchy where there are rigid divisions between junior, senior, enrolled, assistant and registered nurses (Marks, 1994), with less qualified nurses performing more menial and less 'medical' tasks (Rispel et al., 1989).

In addition, nurses are often victims of burn-out and low morale. This is particularly evident in black nurses in South Africa who have suffered gender, racial and occupational oppression (Marks, 1994). In this regard, historically, the nursing profession was initially dominated by English 'lady nurses' drawn from the middle classes and educated overseas. This picture shifted in the 1930s and 1940s, when large numbers of white working class Afrikaner women were recruited into the profession, reaching 70% of the total by mid-century (Marks, 1994).

Furthermore, nursing underwent a further shift with the introduction of apartheid in 1948. The racial ideology of the apartheid system dictated that white nurses could not take care of black patients, which demanded that large numbers of black nurses be trained, leading to an exponential growth in numbers from 800 black nurses in 1948 to 10 000 in 1990 (Marks, 1994). Although in the 1950s, African nurses were drawn from the most educated sector of the black population, the introduction of large numbers of African women into the nursing profession in South Africa, threatened, however, the status of nursing as a respectable occupation for white women (Marks, 1994).

A solution to this dilemma was found in the racial segregation of the Nursing Council and Nursing Association in 1957. Although black nurses passed the same examinations, they suffered discrimination in terms of lower salaries, employment benefits and inferior training facilities. According to Marks

(1994), although black nurses experienced status and wielded a tremendous amount of power in their own communities, the opposite was, however, the case in relation to their status within the nursing profession. Further, black primary health care nurses who, under the apartheid era, effectively performed the duties of medical doctors in many of the townships and rural areas where doctors were scarce, were further undermined by a proviso in the Nursing Act which stated that they could only diagnose and dispense medication provided a doctor was unavailable (Marks, 1994). According to Dennill (1999), a similar situation persists to date, where nurses are expected to take over tasks normally assigned to medical doctors, but only under certain conditions, and only when it suits the public sector, normally in situations where doctors are unable to cope.

5.3.2 Organization and management of nursing in South Africa

Given the need to understand nursing contextually, it is important to understand the role played by the management and organisation of nursing in sustaining the care provided at the primary level. This needs to be further understood within the context of the health system functioning as a bureaucracy which may itself need to be challenged.

According to Weber (cited in Clegg, 1994), who is regarded as having developed one of the most comprehensive understandings of bureaucracies, this form of organisation emerged with the advent of the era of modernisation and industrialisation. While Weber suggests that within large organisations, bureaucratization is the most efficient form of organisation, he counters this by a concern that it also functions as a form of social control which ultimately restricts individuality and autonomy, and produces in people a 'restricted personality' (Weber, cited in Clegg, 1994). He suggests that bureaucratic forms of organisation are characterised by, inter alia: specialisation (division into specialised roles); standardisation (standard rules and procedures); normalisation (written instructions and procedures); centralisation (of decision

making); and configuration (long versus short chains of command) (Clegg, 1994).

These characteristics are considered to be inimical to the provision of comprehensive approach to care as conceptualized in Chapter Three. In this regard, given the idiographic and situational nature of illness, comprehensive care requires the capacity, on the part of health care personnel, to act and think autonomously, as well as to have multiple skills as opposed to specialist skills and defined task functions.

Nursing management is, however, bureaucratic, being characterized by centralization of control with associated power hierarchies and rule bound behaviour. The mechanism for increasing efficiency in the nursing system is typically through supervision and monitoring of activities, as well as the sub-division of tasks so that simpler ones can be undertaken by less skilled and lower paid workers (Walby, Greenwell, Mackay & Soothill, 1994). The latter is evident in the internal hierarchy within nursing. As already mentioned, there are rigid divisions between junior, senior, enrolled, assistant and registered nurses with the less qualified performing more menial and less 'medical' tasks (Rispel et al., 1991). This specialization is, however, regarded as counter-productive to the provision of comprehensive care which requires that the idiographic and situational nature of illness be taken into consideration.

Furthermore, according to Mgoduso et al. (1992), while primary health care nurses are supposed to be responsible for the health needs of the community, they do not have the power or authority to carry out this task. Responsibility without authority leads, however, to frustration, which contributes to burn-out. Moreover, Mgoduso et al. (1992) suggest that nurses subordinate position within the health care system contributes to the authoritarian attitudes that they have been found to display towards their patients. This concurs with the findings of May (1995), who reviewed a number of studies

which suggest that the quality of the nurse-patient relationship would be improved if nurses were given more control over their labour.

Authoritarian attitudes by nurses towards patients, which is commonplace in the South African context (cf. Jewkes, Abrahams & Mvo, 1998), also needs to be understood, however, within the historical context of nursing. To quote Jewkes et al. (1998):

> "Nurses are... engaged in an unremitting struggle to claim a status and respect as a middle class profession within environments in which political, professional, historical and personal factors continuously undermine this claim. Nurses at a clinic level thus become embroiled in continuous struggles to assert a middle class identity through continuous striving to create social distance from patients. In this struggle, uniform and insignia (epaulettes), verbal assertions of distance, displays of lack of compassion and ultimately physical violence are all deployed" (p. 1793).

5.4 Conclusion

Taking into consideration the need for a contextual understanding of nursing care, I have chosen to adopt the Tavistock model of organizational change as the guiding conceptual framework for the analysis of the emergent data. This model was deemed appropriate in that it not only alerts one to the need to consider issues at a structural level and within the macrocontext that may impede the provision of a comprehensive discourse of care, but also highlights the need to consider issues operating at an unconscious level.

Using this conceptual framework, together with the contextual understanding of nursing care in South Africa, the following chapter provides a discussion of my findings in relation to the three research questions posed.

CHAPTER 6

DISCUSSION OF RESULTS

6.1 Introduction

In this chapter I discuss my research findings in relation to the research questions posed. With regard to the first research question, which pertains to my second objective, quantitative research was used to evaluate whether the reorientation programme effected a shift towards comprehensive care by the nurse participants. This is reported on first. Given that the post-assessment audio tape for one of the nurse participant's patient consultations was damaged, results are only reported for five of the participants. Qualitative inquiry using ethnographic methods was used to answer the second research question, posed to meet my third objective, which was concerned with developing an understanding of the factors which mediated the capacity of the nurse participants to provide comprehensive care. This is reported on next. Finally, the findings pertaining to the third research question, posed to meet my fourth objective are reported on last. This objective was concerned with increasing my understanding of factors which serve to impede the transformation of the health care system to one which is supportive of a comprehensive discourse of care at the primary level.

6.2. First research question: Did the reorientation programme effect a shift towards comprehensive care by the primary health care nurses?

6.2.1 Inter-rater reliability

As indicated in the methodology section, inter-rater reliability for the two independent judges was calculated for each indicator using percent

agreement. Given that percent agreement is calculated using categorical data, the ratings of absent and poor were collapsed into the category of inadequate; and adequate and good were collapsed into the category of adequate.

The inter-rater reliability results are contained in Table 3 (p. 143). According to Hartmann (1982), satisfactory reliability for percent agreement should be greater than .70. Analysis of the percent agreements contained in Table 3 (p. 143) reveals that observer reliability fell within this range for most of the indicators. A slightly lower percent agreement of .60 was, however, found for the post assessment ratings of open questioning, understanding the patient's explanatory model of illness, and development of a biopsychosocial and cultural formulation of the problem. Given that a percent agreement of .60 falls just below the suggested percent agreement for reliability, together with the fact on all these indicators, satisfactory reliability was found on the pre-assessment ratings, I suggest that these lower reliabilities should not effect the interpretation of the mean difference scores to any great extent.

6.2.2 Analysis of mean difference scores for the indicators of comprehensive care.

The mean difference scores between the post-assessment ratings and the pre-assessment ratings were calculated for each indicator used to evaluate relationship skills (see Table 4, p. 144), micro-counselling skills (see Table 5, p. 145), problem identification (see Table 6, p. 146), and problem management (see Table 7, p. 147).

With regard to *relationship skills*, in the pre-assessment, the subjects were rated by the two independent raters as having these qualities in varying degrees. This suggests a pre-existing variation in these qualities in the subjects, with some having the necessary qualities to establish a

Table 3: Percent agreement by the two raters on indicators of comprehensive care when collapsed into categories of adequate and inadequate.

Skills for comprehensive care	Indicator	Percent agreement (pre-assessment)	Percent agreement (post-assessment)
Relationship skills/qualities	Empathy	.80	.80
	Genuineness	.80	1.00
	Non-possessive warmth	.80	.80
Microcounselling skills	Open questioning	.80	.60
	Use of minimal encouragers	1.00	.80
	Reflection	.80	.80
	Paraphrasing and summarizing	1.00	.80
Problem identification using the framework provided by the meaning centred approach	Inquiring about associated illness problems	1.00	.80
	Understanding the patient's understanding of illness causation	1.00	.60
	Reaching a common understanding of the problem and its treatment	1.00	.80
	Developing a biopsychosocial and cultural formulation of the problem	.80	.60
Problem management	Inviting the patient to participate in the generation of solutions to the problem	1.00	.80
	Reaching consensus on appropriate interventions	1.00	.80
	Empowering the patient to act on these interventions	1.00	.80

Table 4: Mean difference scores between pre and post assessment on indicators of relationship skills

	Empathy				Warmth				Genuiness			
	Pre		Post		Pre		Post		Pre		Post	
	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2
	Mean rating		Mean rating		Mean rating		Mean rating		Mean rating		Mean rating	
				Mean difference score				Mean difference score				Mean difference score
Subject 1	2.0	1.0	3.0	3.0	2.0	1.0	3.0	3.0	2.0	1.0	3.0	3.0
	1.5		3.0	1.5	1.5		3.0	1.5	1.5		3.0	1.5
Subject 2	2.0	1.0	2.0	2.0	3.0	1.0	3.0	2.0	3.0	2.0	3.0	2.0
	1.5		2.0	0.5	2.0		2.5	0.5	2.5		2.5	0.0
Subject 3	3.0	3.0	3.0	1.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
	3.0		2.0	-1.0	3.0		3.0	0.0	3.0		3.0	0.0
Subject 4	2.0	2.0	3.0	4.0	3.0	2.0	4.0	4.0	3.0	3.0	4.0	4.0
	2.0		3.5	1.5	2.5		4.0	1.5	3.0		4.0	1.0
Subject 5	2.0	3.0	4.0	3.0	2.0	3.0	4.0	4.0	3.0	3.0	4.0	4.0
	2.5		3.5	1.0	2.5		4.0	1.5	3.0		4.0	1.0

Table 5: Mean difference scores between pre and post assessment on indicators of microcounselling skills

	Open questioning				Minimal encouragers				Reflection				Summarizing/paraphrasing			
	Pre		Post		Pre		Post		Pre		Post		Pre		Post	
	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2	Rater 1	Rater 2
	Mean Rating		Mean Rating		Mean Rating		Mean Rating		Mean Rating		Mean Rating		Mean Rating		Mean Rating	
Subject 1	1.0	1.0	2.0	3.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0	2.0	1.0	1.0	2.0	2.0
	1.0		2.5		1.0		1.5		1.0		1.5		1.0		2.0	
Subject 2	1.0	2.0	1.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0	2.0
	1.5		1.5		1.0		1.0		1.0		1.5		1.0		1.5	
Subject 3	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
	1.0		1.0		1.0		1.0		1.0		1.0		1.0		1.0	
Subject 4	2.0	3.0	2.0	4.0	1.0	2.0	2.0	3.0	1.0	3.0	1.0	3.0	1.0	1.0	3.0	2.0
	2.5		3.0		1.5		2.5		2.0		2.0		1.0		2.5	
Subject 5	1.0	1.0	3.0	4.0	1.0	1.0	3.0	3.0	1.0	1.0	3.0	3.0	1.0	1.0	3.0	3.0
	1.0		3.5		1.0		3.0		1.0		3.0		1.0		3.0	

Table 6: Mean difference scores between pre and post assessment on indicators of problem identification

	Inquiry about assoc. illness problems			Understanding patients explanatory model of illness			Common understanding of the problem			Biopsychosocial and cultural understanding of the problem		
	Pre	Post	Mean difference score	Pre	Post	Mean difference score	Pre	Post	Mean difference score	Pre	Post	Mean difference score
	Rater 1 Rater 2 Mean Rating	Rater 1 Rater 2 Mean Rating		Rater 1 Rater 2 Mean Rating	Rater 1 Rater 2 Mean Rating		Rater 1 Rater 2 Mean Rating	Rater 1 Rater 2 Mean Rating		Rater 1 Rater 2 Mean Rating	Rater 1 Rater 2 Mean Rating	
Subject 1	2.0 1.0 1.5	2.0 3.0 2.5	1.0	2.0 1.0 1.5	3.0 3.0 3.0	1.5	1.0 1.0 1.0	3.0 2.0 2.5	1.5	2.0 1.0 1.5	3.0 2.0 2.5	1.0
Subject 2	2.0 1.0 1.5	2.0 2.0 2.0	0.5	2.0 1.0 1.5	1.0 2.0 1.5	0.0	2.0 1.0 1.5	2.0 1.0 1.5	0.0	2.0 1.0 1.5	2.0 1.0 1.5	0.0
Subject 3	2.0 1.0 1.5	2.0 1.0 1.5	0.0	1.0 1.0 1.0	1.0 1.0 1.0	0.0	2.0 1.0 1.5	2.0 1.0 1.5	0.0	1.0 1.0 1.0	1.0 1.0 1.0	0.0
Subject 4	3.0 3.0 3.0	3.0 3.0 3.0	0.0	1.0 2.0 1.5	1.0 3.0 2.0	0.5	2.0 2.0 2.0	2.0 2.0 2.0	0.0	3.0 1.0 2.0	3.0 1.0 2.0	0.0
Subject 5	1.0 1.0 1.0	3.0 2.0 2.5	1.5	1.0 1.0 1.0	3.0 2.0 2.5	1.5	1.0 1.0 1.0	2.0 3.0 2.5	1.5	1.0 1.0 1.0	2.0 3.0 2.5	1.5

Table 7: Mean difference scores between pre and post assessment on indicators of problem management

	Participation			Consensus			Empowerment		
	Pre	Post	Mean difference score	Pre	Post	Mean difference score	Pre	Post	Mean difference score
	Rater 1 Rater 2 Mean rating	Rater 1 Rater 2 Mean rating		Rater 1 Rater 2 Mean rating	Rater 1 Rater 2 Mean rating		Rater 1 Rater 2 Mean rating	Rater 1 Rater 2 Mean rating	
Subject 1	1.0 1.0 1.0	3.0 1.0 2.0	1.0	1.0 1.0 1.0	3.0 1.0 2.0	1.0	1.0 1.0 1.0	2.0 2.0 2.0	1.0
Subject 2	2.0 1.0 1.5	2.0 1.0 1.5	0.0	2.0 1.0 1.5	2.0 2.0 2.0	0.5	1.0 1.0 1.0	1.0 1.0 1.0	0.0
Subject 3	1.0 1.0 1.0	1.0 1.0 1.0	0.0	2.0 1.0 1.5	2.0 1.0 1.5	0.0	1.0 1.0 1.0	1.0 1.0 1.0	0.0
Subject 4	2.0 1.0 1.5	3.0 3.0 3.0	1.5	2.0 1.0 1.5	3.0 3.0 3.0	1.5	2.0 2.0 2.0	3.0 3.0 3.0	1.0
Subject 5	1.0 1.0 1.0	4.0 3.0 3.5	2.5	1.0 1.0 1.0	3.0 3.0 3.0	2.0	1.0 1.0 1.0	3.0 3.0 3.0	2.0

comprehensive care relationship prior to the reorientation and training programme. With the exception of one subject (subject 3, Table 4, p. 144), the positive mean difference scores also indicate that the training programme served to improve these qualities in most cases.

With regard to *microcounselling skills,* with the exception of subject 4, all the other subjects were rated as being inadequate on indicators of this dimension in the pre-assessment. Following the reorientation and training programme, positive mean difference scores were, however, noted for all subjects with the exception of subject 3, indicating that the programme also had a positive effect on this dimension in most cases.

With respect to *problem identification,* with the exception of subject 4, all the other subjects in the pre-assessment were rated by both judges as inadequate on the indicator measuring inquiry about associated illness problems. The post assessment ratings indicate, however, that the programme had served to raise an awareness of the need to inquire about associated illness problems, with subjects 1,2 and 5 displaying positive mean difference scores on this indicator. Subject 3, was again the exception, showing no improvement on her inadequate ratings after the reorientation and training programme.

With regard to the other indicators on this dimension, while in the pre-assessment, none of the subjects was found to actively engage patients in exploring their subjective experiences of their illness; three of the subjects were rated as showing an improvement on this indicator in the post-assessment.

With respect to the indicator measuring a negotiated understanding of the problem, none of the subjects was rated positively on this indicator in the pre-assessment, with only two subjects (subjects 1 and 5) showing an

improvement in the post assessment. Furthermore, these same two subjects were the only two who showed an improvement on the indicator measuring a biopsychosocial and cultural formulation of the problem in the post assessment.

Finally, with regard to *problem management,* none of the subjects was found to engage adequately with patients in problem management prior to the programme. The programme was, however, found to have a positive effect on this dimension for three of the subjects (subjects 1, 4 and 5), with subject 3 showing no improvement and subject 2 only a marginal improvement (0.5) on only one indicator.

6.2.3 Discussion of findings from the quantitative analysis

The results of the quantitative analysis which constituted the programme evaluation component of the evaluation study, indicate an inter-subject variation in the extent to which the programme was successful in effecting a shift in the care provided across the nurse-participants. Furthermore, they also revealed an intra-subject variation in how well the programme was able to effect a shift on the different indicators of comprehensive care for each nurse-participant.

Only two subjects (subjects 1 and 5) showed a consistent positive mean difference score on all the indicators. Furthermore, while subject 4 did not always show an improvement, in many instances she had been rated adequately on the indicators in the pre-assessment. Notable exceptions in this regard, were, however, her low pre and post ratings on the indicators measuring exploration of a patient's explanatory model of illness as well as illness negotiation. Inter-rater agreement on adequate performance on this indicator was, in fact, found in the post-assessment ratings for only one case

(subject 1), indicating that the results pertaining to this indicator for the other subjects were questionable and required further investigation.

Another finding that required further investigation was that subject 3 showed no improvement on any of the indicators of the dimensions measured. Even though she was found to display the qualities identified as being necessary to facilitate comprehensive care (see Table 4, p. 144), she was rated as inadequate on all the other indicators measuring the provision of comprehensive care both in the pre and post assessment.

In the final analysis, it could be stated that the programme was successful in varying degrees both across and within subjects in effecting a shift towards a comprehensive approach to care. As with most programme evaluation research, the quantitative study does not, however, provide information as to why these variations occurred. In order to understand this more fully, the qualitative analysis, which follows, provides some insight into the factors which determined these variations.

6.3 Second research question: What were the factors which mediated the capacity of the nurse participants to provide comprehensive care following the reorientation and training programme?

The purpose of this qualitative analysis was to meet my third objective, namely, to develop an understanding of the factors which mediated the capacity of the nurse participants to provide comprehensive care following the reorientation and training programme. In this respect, this analysis also proved useful in giving meaning to some of the results obtained in the quantitative evaluation study.

Through the process of analysis which was explicated in Chapter Four on methodology, and using the conceptual and contextual framework discussed in Chapter Five, the following emergent themes were conceptualized as factors mediating the provision of comprehensive care by the nurse participants.

Anxiety over having to help patients with psychosocial and psychological problems.

All the primary health care nurses interviewed prior to the reorientation and training programme understood the importance of using a holistic framework to intervene with health problems reflected in the following excerpts from interviews where they were asked about their role in relation to dealing with associated illness problems:

> Yes, because if you ignore these other problems a person can't get well - it's better to take all problems into account

and

> Yes, we have to look at the problem, the symptoms and other aspects, if you feel the patient is not okay

I found that this perception was, however, generally not translated into practice. In my observations of nurse-patient consultations prior to the reorientation and training programme, I found that the nurses avoided dealing with psychological and psychosocial problems in the following ways.

Firstly, in cases where *psychological/psychosocial problems were overtly raised*, I developed the following typology of how nurses dealt with this scenario. I observed that the nurses either chose to avoid discussing these problems, thus rendering them *'invisible'*, or *coerced* patients into acting in particular ways by giving advice. Coercion involves the use of power to persuade people to act in particular ways. I interpreted the advice given by the nurses as coercion given the power that they wield in the nurse-patient relationship.

With regard to the first strategy within the typology, the following excerpt from a nurse-patient consultation demonstrates how psychological problems were made invisible. While on the one hand, the nurse realised that the presenting complaint may have been caused by psychological problems, she chose to avoid any further discussion on the problem and tried to provide a medical explanation. When this failed she placated the patient with medication.

> *Nurse:* You said you cannot sleep at night. Is there anything bothering you perhaps.
>
> *Patient:* I think too much and my heart beats fast.
>
> *Nurse:* Thinking too much can cause lack of sleep, high blood pressure can cause that as well. I don't mean that you have high blood pressure, but I would like to check you anyway. No, your blood pressure is fine. I don't think that it's that that causes you lack of sleep. It must be thinking too much then. I will give you pills for your feet and something for your itchy face. Keep your medication away from children.

The following excerpt, in which the patient complained of being kicked by her husband, demonstrates the use of coercion as a strategy for dealing with psychosocial problems.

Nurse: We cannot dispute which is better or not but of equal importance is your relationship as husband and wife. It is important that it is not disrupted. You must reason with him and understand that days are not the same. He doesn't booze every day? ... Well you will see what you can do. Your husband drinks and there is nothing you can do about it. I do not mean ply him with alcohol but give him sometimes when he asks.

Secondly, in cases where *somatic complaints are commonly linked to psychological problems*, with the exception of one nurse, the following typology characterised the nurses' approach to dealing with the problem. I observed that exploration of illness related problems were avoided. Only the overt physical aspects of the problem were treated as is demonstrated by the following excerpt from a consultation with a patient suffering from stomach ulcers.

Patient: Sometimes it hurts when I have had something hot like tea.

Nurse: Oh, maybe you are going to have ulcers. These are small sores inside of you, you must be careful and not eat hot foods like pepper. What about alcohol? Do you indulge?

Patient:..

Nurse: (laughs) Well, you have to make sure that you do not do it on an empty stomach. You must eat first, and if you like food with pepper or you like to eat hot chutney, make sure that you have something on your stomach first, and drink a lot of water, plain water before you eat. Take this medicine, one spoon three times a day before meals. Do not eat immediately after you have taken this. You must wait a while and shake the bottle before. Okay? Keep well. Bye.

While the cause of this problem could have been physiological and require medication, it is equally important to consider other aspects contributing to the maintenance of the problem.

Thirdly, when *no physiological basis for somatic complaints* could be identified, the typology that emerged was that the nurses generally failed to take contextual or emotional factors into consideration, which I also interpreted as avoidance of these issues. This is demonstrated by the following excerpt from a consultation in which the patient's chief complaint was that her whole body 'hurt', her bones felt 'cold' and she felt faint. The patient also requested a letter putting her off work for three days.

> *Nurse*: We no longer write letters but only the clerks do them now. Why do you want to start working on Wednesday, because you are not that seriously sick? What will the kids eat if mummy doesn't go to work ?
>
> *Patient*: I need energy sister I thought I was going to die.
>
> *Nurse*: Let me check your blood pressure... let me see your tongue. It seems fine. Maybe you worked too hard that is why you were hurting. I just checked your blood pressure as you told me that you feel faint. It is normal. I have checked your eyes and your tongue to see if you have enough blood in your system... that is how we can tell. All seems to be in working condition. I will give you some pills to help your blood circulation, take them after food three times a day. The clerk will give you the letter to say you came to the clinic today. Give him this card and he will help you. Be sure to take your medication.

While prior to the reorientation and training programme, the nurse participants were aware of the need to understand and treat their patients holistically, this was rarely translated into practice as demonstrated by the above excerpts. These findings support international findings (e.g., Harding, et al., 1980; Freeman, 1991; Goldberg et al., 1992), that primary health care personnel only identify and treat the presenting physical complaints associated with common mental health problems. Furthermore, these findings reinforce Rispel et al.'s (1991) argument that the holistic ideology of nursing care has, in

South Africa, been subsumed by biomedicine. Furthermore, these findings corroborate with Strasser et al.'s (1999) contention that care provided at the primary level remains largely biomedical in orientation. This suggests a disjuncture between the policy principles for comprehensive primary health care and the actual care provided at the primary care level.

From a psychoanalytic perspective, I interpreted these findings as reflecting an anxiety on the part of the nurse participants over having to deal with psychosocial and psychological problems. Strategies of avoidance or coercion were used as a defence against having to deal with these problems. Most associated illness problems were related to social and family problems as is illustrated by the following excerpts from interviews with the nurses:

> Most of the patients - they are unemployed - so they worry about the finances - some have problems at home.

and

> I think the social conditions, there's a high rate of unemployment of people who live here.

In the face of these problems the nurses expressed a sense of being overwhelmed and displayed feelings of anxiety, guilt, and frustration in relation to not being able to help patients adequately with these problems, as is illustrated by the following excerpts from interviews with them.

> It is a difficult position, because sometimes what makes it worse is that sometimes you are too busy; you don't even have enough time to attend and yet she needs so much time with you, you can't offer that time - you just do it haphazardly. Then you are relaxed at home, you say I should have sat with her and talked with her.

and

> Well as nurses we are just piled with a pile of problems... but you feel responsible for helping.

While lack of time is a real concern, Henbest and Fehrsen (1992) suggest that a patient-centred approach is not more time consuming. I therefore wished to explore this anxiety in greater depth. The following themes represent my attempts to unpack and understand this anxiety more fully.

Anxiety over lack of knowledge and skills to deal with psychological and psychosocial problems

One of the issues that emerged as contributing to the use of avoidance or coercion as strategies for dealing with patients with psychological and psychosocial problems prior to the reorientation and training programme was an anxiety over their lack of competence to deal with such problems. In the pre-programme interviews they expressed the view that they did not have the skills to provide such care, as exemplified by the following excerpt from an interview.

> ... but the problem is we don't have enough knowledge about the psychological problems so we try to help although we think its not good enough.

When I interviewed the nurses after the training programme, I found, however, that all indicated that their approach to patient care had changed as a result of the training. They indicated that they were more aware of the need to inquire about associated illness problems, as is illustrated by the following excerpt of an interview with one of the nurses:

> It is because now I know that I have to talk to the patient and listen to the patient and not just give medicine only - just to understand other aspects of the patient - to treat the patient holistically.

I interpreted these findings as indicating that the training programme had functioned to increase the nurses' knowledge and awareness of the need to not only deal with the disease aspects of illness, but to also inquire about associated illness problems. Furthermore, with the exception of one nurse, they expressed a feeling of being empowered with skills to help patients with psychosocial problems as the following excerpt illustrates:

> Before when I had a client I used to wonder whether I should do this or do that or is this going to be helpful or make things worse but now I see myself being able to deal with the problems better.

This excerpt suggests a reduction in anxiety around competence to deal with psychological and psychosocial problems. Furthermore, I found that this perception that their approach to patient care had changed as a result of the programme, was translated into practice in varying degrees (also see quantitative analysis), indicating that the programme had played an important role in reducing anxiety around competence.

The following excerpt from a nurse-patient consultation in the post-assessment, where the presenting problem was a sexually transmitted disease, demonstrates the positive impact of the training on shifting patient care towards a comprehensive approach.

> *Nurse*: Is your boyfriend having any problems, sexually transmitted diseases perhaps?

Patient: Well, I haven't heard anything from him because, well I don't know how to explain this. I stay in his home because I have his children and I cannot be a burden to my mother. Sometimes I get odd jobs but most of the time I am not working and my children are weak. They need to be near their father and there is nobody to take care of them if I were to stay at my mother's house... Our living arrangement is that he has his own hut and I have mine. He brings women every now and again. Sometimes he may call me for sex but he does that rarely like the last time I was with him was during the Easter holidays, and before that we had sex in January.

Nurse: He was intimate with you during the Easter holidays and before it was January. Is he married to someone else?

Patient: No I am the only wife he has. There is no-one else except for his string of girlfriends. He has quite a number of them because even in the neighbourhood I can't even talk freely with anyone because people will tell me that I am a fool for the person I am laughing and joking with may have spent the night with him. He doesn't even discriminate in terms of age - young girls, ladies and even older women.

Nurse: Mnh...You said he has his own hut and you have your own. Whose decision was that?

Patient: His because he wanted to bring his girlfriends home. I just stay with the kids.

Nurse: Do you like what he is doing?

Patient: Well I don't like it...I know I should go back home. The problem is that my mother is alone at home - I never had a father. I do not have a job - I would be a burden. The kids are quite grown up - they are at school and I haven't even paid for their fees yet. He doesn't help with the kids at all, their education or food. I really do not know why I stay there.

Nurse: He doesn't buy food. You have to fend for yourself to find something to eat!

Patient: Yes, sometimes I do some washing for somebody and repair the mud walls of somebody's hut if they ask me. As I said there is really no reason why I stay there. It is just that I do not want to be a burden. I even had to take my girl out of school. She is fifteen.

Nurse: Now how does it feel staying with him when he behaves like that?

Patient: It is only for the children, because they get sick when they are not at home. As far as I am concerned it hurts but there is nothing I can do but bear it.

Nurse: I see. You haven't perhaps thought of what you might do to help yourself and the kids..?

Patient: Like what?

Nurse: What ever you think might help you.

Patient: There is nothing except perhaps if I were to get a job.

Nurse: What would you do if you got a job?

Patient: I would help support my kids, buy them food and send them to school.

Nurse: And where would you stay?

Patient: I would go back to my mothers house...

Nurse: Right now where do you get food from?

Patient: The lady who brought me here helps me a lot...

Nurse: Do you ever speak to your neighbours about finding a job?

Patient: Yes, they help me a lot - tip me off if somebody needs someone to do their washing etc.

Nurse: Okay

(interruption - a nurse comes in the consulting room)

Nurse: I'm terribly sorry about the interruption. The fact that he brings girlfriends home. Does it not bother you that you might get sexually transmitted diseases.

Patient: I do think about that and I am especially afraid about this incurable disease.

Nurse: Is he aware of such a disease?

Patient: Yes, people tell him but he won't listen. The thing is that I don't know whether he uses anything with them or not.

Nurse: Does he use anything with you?

Patient: Nothing, he won't use anything with me.

Nurse: What would you like him to use?

Patient: I tell him that I need to collect a condom from the clinic but he says that it is for prostitutes and school kids.

Nurse: He says that! Have you ever collected one from here?

Patient: No, I have never taken it because he hates it. He once beat me up when I gave him one that I got from a friend. He said I had an affair...

Nurse:...If you were to ask him to come here to have a talk with us do you think he would agree?

Patient: No he wouldn't. No way!...

Nurse: He does need to be educated about the use of condoms as you said that he likes women. This might put you in danger of being infected with a disease if he were to meet a women who

is infected with a virus. You must try and talk to him and beg him to come to the clinic so that we can try and give him some advice about the use of condoms...

Patient: I don't know. It is difficult because he does not talk to me at all. Sometimes when I try to talk to him- he just leaves the room.

Nurse: Aren't there elders at home who can help you talk to him?

Patient: He does not have parents.

Nurse: Relatives?

Patient: He does have a sister but she does not like me - and his relatives cannot talk to him...

Nurse: Do you have a community health worker close to your house?

Patient: Yes I do. Mrs Blose.

Nurse: Do you think he would listen to her if she were to speak to him?

Patient: She could try. Maybe because he knows that she is something in the community he might listen to her...

This excerpt demonstrates how the nurse, through inquiring about associated illness problems, managed, in the first instance, to identify the cause of the presenting problem. Furthermore, using the problem management model, she was able to empower the patient to think of ways she could deal with her problem, as opposed to just treating the presenting symptoms and providing information on how to prevent HIV infection. Moreover, this excerpt also demonstrates the importance of addressing associated illness problems for facilitating health promotion, particularly around dealing with health related behavioural problems.

Anxiety over lack of support for the provision of comprehensive care

From the interviews with the nurse participants, a typology that emerged in relation to the nurses' emotional responses to providing comprehensive care was that they felt drained and 'burnt-out', and in need of psychological assistance themselves. They complained of a lack of support both technically and emotionally from their superiors as indicated from the following excerpts from the focus group interview.

> The matron, or whoever is in charge, at least should be trained in that field, because you find that sometimes you may be psychiatrically trained but the person who is in charge of you is not psychiatrically trained. Whilst you maybe talking about something important, she doesn't see anything important.

and

> We don't get support or anything - we need a social worker who's going to attend to our social problems.

From a psychoanalytic perspective I interpreted these findings as being reflective of an anxiety over not being able to help patients adequately because they lacked containment for their own issues. Emotional labour requires that one's own issues are contained so that one can provide support for others. It has been described as:

> "the induction or suppression of feeling in order to sustain an outward appearance of calm that produces in others a sense of being cared for in a convivial safe place" (Smith, 1989, p. 49).

Furthermore, technical support is also important. As Swartz (1998) suggests, gaining confidence in the provision of counselling is a lengthy process, requiring the provision of back-up support, as well as ongoing training (Swartz, 1998). This is well illustrated by the following excerpt from an interview with one of the nurse participants who expressed a lack of confidence.

> Yes, I've tried, it's only, it's not that it is difficult but I still feel like I need more skill in it because I might mismanage some of the patients.

In attempting to understand more fully why this particular participant expressed a lack of confidence, even following the reorientation and training programme, it emerged that she was having personal difficulties, as her husband had been suffering from a terminal illness. She was thus particularly in need of support herself, and in the post assessment interview repeatedly requested for more training and support.

I observed that this lack of confidence was in fact reflected in her consultations with patients where she failed to adequately engage with any of her patients using the problem management model. This finding is corroborated by the quantitative analysis (see subject 2, Table 7, p. 147) and reinforces the need for containment of nurses' own issues if they are expected to provide emotional labour.

Anxiety associated with being 'too close' to patients

My observations of nurse-patient interviews revealed that there was one nurse (subject 3 in the quantitative analysis) who consistently ignored associated illness problems before and after the training, even when the need

for such exploration was obvious, as is illustrated by the following excerpt from the post assessment observations:

> *Patient*: I can't sleep at night.
>
> *Nurse*: So your worms did not come out at all.

While this particular nurse was rated in the quantitative study as displaying adequate relationship skills for comprehensive care (see subject 3, Table 4, p. 144), in addition to her lack of inquiry about associated illness problems, she was consistently rated as being inadequate on all the other dimensions of comprehensive care (see subject 3, Table 5, p. 145; Table 6, p. 146; and Table 7, p. 147). I suggest that, while she demonstrated an awareness of the need to inquire and deal with associated illness problems, her anxieties associated with dealing with patients' psychosocial problems had not been addressed by the reorientation and training programme. She continued therefore, after the programme, to avoid dealing with these problems in her consultations with her patients.

In trying to understand the source of her anxieties it emerged that while all the nurses felt burdened with the social problems experienced by patients, hers was particularly acute as is illustrated by the following excerpt from an interview with her:

> Some, they even end up asking for jobs from us, maybe washing for two days and then... they say even can I get them something for one day, we say okay we'll see what we can do.

I understood this problem to be exaggerated for this particular nurse (subject 3 of the quantitative analysis) because she was the only nurse who lived in the same area as the clinic she serviced, which made it difficult for her to escape community needs. Consequently, she was often burdened with patients' social problems, during and after clinic hours, as is illustrated by the following excerpt from an interview with her:

> Some even come to see me at home when I'm off, because I stay here - like a social worker.

From a psychoanalytic perspective, in the absence of support, I interpreted her adherence to providing purely biomedical care as serving to relieve her of feelings of anxiety and guilt around a sense of impotency in the face of the enormity of the associated illness problems in her community which were largely poverty related. To quote:

> Stress is a big cause... I feel helpless to help in these cases.

Furthermore, she appeared to use schizoid splitting as a defense. In the first instance, she located the responsibility for care of psychosocial problems with the social worker and not with herself. Secondly, in cases where there were overt psychosocial problems, I found that she located the blame for the patient's predicament within the individual as is illustrated by the following excerpt from an interview with her:

> Some have social problems at home - but don't want to get involved in projects like gardening.

I suggest that anxieties associated with caring for patients' associated illness problems in addition to their medical problems were more prominent for this particular nurse than for the other nurses given her lack of geographical distance from her patients. This made it difficult for her to escape the source of patients' problems, which were largely poverty related, and thus also threatened her own material well-being.

The need for distance to function effectively as a health care worker is supported by recent findings by Van der Walt (1998) who suggests that a difference in class, race, income and educational standards between nurse and patient provides a measure of distance for the nurse, which in turn allows her to be more empathic and understanding of a patient's predicament. Furthermore, Van der Walt suggests that nurses who have grown up under similar social conditions to their patients find patients' problems 'too close for comfort'. They expect patients to lift themselves out of their situations much the same way that they did, and often adopt a scolding attitude towards their patients (Van der Walt, 1998). This problem can therefore be expected to be exacerbated in situations where nurses continue to live in these same conditions as was the case with subject 3 of the quantitative analysis.

In support of my interpretation, I found that the only nurse who inquired about associated illness problems prior to the reorientation and training programme (see also quantitative analysis, subject 4, Table 5, p. 145) came from a higher socio-economic stratum to the other nurses and lived in an affluent middle class suburb. While patients did not expect assistance with psychosocial problems, I observed that patients perceived this nurse to be more caring. Consequently, she was very much in demand as is illustrated by the following quote by a patient:

Patient: You have a good heart sister. Everybody is talking about you outside. One said that she is hoping that when it is her turn she will get to come this side because you treat everybody so well.

I suggest that this particular nurse was able to engage patients with broader psychosocial problems as her higher socio-economic class and geographic location of her home created a fair amount of distance.

As Swartz (1998) suggests:

> "health professions, and mental health professions in particular, depend partly for their success on a power differential and some distance between the clinician and the group served by the clinician" (Swartz, 1998, p. 249).

Anxiety over loss of power and status associated with biomedicine

While in the quantitative analysis, two of the nurses (see subjects 1 and 5, Table 6, p. 146) were both rated as showing a positive mean difference score of 1.5 on the indicators measuring culturally congruent care (viz., inquiring about a patient's explanatory model of illness and reaching a common understanding of the problem) my interviews and observations suggest that the nurses adopted a reformist understanding of this concept.

In this regard, a typology which emerged was that they interpreted the meaning centred approach to mean either persuading a patient to understand the etiology of their illness from a medical perspective or to incorporate the patient's explanatory model of illness into the consultation in order to ensure treatment compliance. The first strategy is exemplified by the

following excerpts from interviews with nurses where they expressed difficulty with implementing this approach:

> It's so difficult... I think it's the beliefs because some of them have been using the traditional way since birth, and if you try to say this can be treated medically, they do not understand why, they understand the other way round, it takes a lot of time to explain it.

and

> ... that (the meaning centred approach) sometimes seems to be a problem because most of our patients still believe in bewitchment and somehow you have to try and win the patient but it depends - or you let her believe that and try to put another method.

The second strategy of incorporating the patient's explanatory model of illness into the consultation to ensure treatment compliance, is illustrated by the following nurse-patient consultation. It shows how the nurse used the patient's explanatory model of illness to persuade the patient to comply with medical treatment:

> *Nurse*: And did you stop taking those pills?
>
> *Patient*: I was not mad sister, I was just confused because of bewitchment. I had 'izizwe'.
>
> *Nurse*: But the pills were not because you were mad but could have helped you with the confusion so that the 'izizwe' would not harm you. You see now you have stopped taking pills, you can't sleep. Don't you think perhaps the 'izizwe' are coming back?

In order to understand why this typology of culture centred care had emerged, I inquired about this phenomenon in a focus group interview with

the nurses as well as conducted interviews with the psychologist at the community health centre, the nursing services manager and the primary health care coordinator for the district.

One reason that was given related to the hegemony of biomedical ideology in nursing care. To quote the primary health care coordinator:

> The majority of nurses have the attitude that they know everything and the patient knows nothing... they are steeped in biomedical ideology.

While their original training may have socialized them into adopting a biomedical view, I was interested to find out why they held onto this view even after the reorientation and training programme. While the nurses in the focus group interview maintained that lack of time was a mediating factor in the provision of a meaning centred approach to care, the psychologist and nursing services manager suggested that the power and status that nurses derived from their association with biomedical care also needed to be considered. They suggested that engaging patients in discussion about their explanatory models of illness threatened to undermine this power. To quote the psychologist:

> They've (the nurses) got this attitude 'I know what is wrong with you' and, as such, if patients think that this is wrong with me, they would just dismiss that and say if you are feeling this and this and this it means this and this and this is wrong with you... that power thing is very visible with them... also sometimes the patients come with that expectation that you must tell them what is wrong, and I mean they are used to that.

As was suggested by the primary health care coordinator, the need for power and status on the part of nurses needs to be understood as a legacy of South Africa's apartheid history. In this regard, black African nurses have suffered oppression within South African society as a whole, as well as within the health care system specifically, where there were huge inequities on a number of fronts between themselves and their white counterparts, as discussed in Chapter Five. To quote from my interview with the primary health care co-ordinator:

> They need to hold onto the power and status that providing biomedical care gives them. This comes from the oppression that people have been through under apartheid. Power and status commanded respect in the past... if they didn't do that they would sort of feel the community would want to take advantage of them... a lot of things they want to do for themselves and their families whatever to prove that they now are uplifted - have uplifted themselves from whatever situation.

This sentiment corroborates Marks' (1994) and Jewkes et al.'s (1998) suggestion that status is particularly important for black South African nurses in view of their historical position in South African society. In this regard, while black African nurses have been drawn from the most educated sectors of the black population, they have occupied the lowest ranks within the health system. Moreover, they have not only been subject to racial discrimination emanating from the apartheid system, but as female nurses, have also been subject to the subjugation of a male dominated medical system (Marks, 1994).

As suggested by the psychologist, in addition to threatening to erode their power and status in the community they serviced, the meaning centred approach also threatened, however, to erode their status within the health care system. With regard to this problem, traditional healing practices in South Africa have been historically regarded by many health care personnel

as 'backward'. This problem has been exacerbated by prominent black medical practitioners speaking out against traditional healing practices (Bodibe & Sodi, 1997). In this respect, a recent daily newspaper article reporting on an interview with a prominent Sowetan general practitioner, Dr Nthato Motlana, reported him as referring to traditional healing practices as 'mumbo jumbo' (Kennaugh, 1999). According to the psychologist, being seen to accommodate a patient's traditional understanding of illness into a negotiated treatment plan may thus be interpreted as being supportive of traditional belief systems and thus being 'backward' oneself. To quote:

> ...some people look at it as somebody who is backward to believe in those things (because) they don't make sense. I mean... when you talk about it, its not only the nurses... you find even academics, they won't talk about it, but in private... they will consult traditional healers, they do. I mean even people who are high profile... Publicly, they totally say no, it doesn't work... but when things get tough, the first person they go to is the traditional healer.

This sentiment was borne out by the nursing services manager who suggested that this problem could be countered by giving traditional healing status within the health care service. To quote from my interview with her:

> African health professionals will deny believing in traditional healing practices, but privately they will go to these people... the negative attitude (towards traditional healing practices) can be changed towards being a positive attitude if we have policy changes which locate traditional healers at the centres ... incorporate them into the health service.

It follows, therefore, that I found that all the nurses interviewed denied holding any traditional beliefs themselves. In contrast a typology that

emerged was that they appeared to view themselves as playing the role of cultural brokers, introducing patients to biomedical understandings of ill-health as is illustrated from the following excerpt from an interview:

> All we do, we don't look down upon what they believe in... but they must understand that the doctors can also help them... especially we educate them... we tell them that if they feel all the symptoms, come to the clinic, we will give you whatever we will give you, then you can see your traditional people.

Given the nurses' perceptions that they need to 'educate' patients about their illness from a biomedical perspective, they therefore appeared to play the role of cultural brokers, introducing patients to biomedical ideology. This finding corroborates with Marks' (1994) historical analysis of nursing in South Africa which highlighted the role played by black African nurses in the acculturation of patients into the discourse of western scientific medicine. Marks quotes two renowned health practitioners in South Africa as stating: "... scientific medicine had... to conquer witchcraft and nursing (was) its standard bearer" (Marks, 1994, p. 209).

Furthermore, Marks (1994) cites evidence from the history of medicine in colonial Africa and India which suggests that the transmission of biomedical ideology met with more success when mediated by people of the same culture (Marks, 1994). In light of this, and in the face of the paucity of African doctors, juxtaposed with the large numbers of black African nurses in South Africa, it is understandable that nurses have been harnessed by the health care system to play this role.

Given their lack of power in the health system, as well as the need to uplift themselves from conditions of poverty, which has characterised most black

Given their lack of power in the health system, as well as the need to uplift themselves from conditions of poverty, which has characterised most black African communities, it is therefore not surprising that nurses displayed anxiety over engaging with patients' explanatory models of illness, as this threatened to erode their status within the health care system and within their communities. This interpretation does not, however, diminish, but adds to the important role played by their training in socializing them to understand presenting complaints from a biomedical perspective.

From a psychoanalytic perspective, a secondary gain from their 'status' position in their communities could also be that it provided them with a measure of distance which, as argued in the previous theme, was an important factor in containing anxieties associated with the provision of comprehensive care. The power and status wielded by the nurses in this study made patients less likely to talk to them about personal problems, as is illustrated from the following excerpt from an interview with the nursing services manager.

> You know the patient walks in here from this community especially - when she wants something she'll go to a junior category... mothers are talking freely to them - but when a professional somebody comes in they switch off - they're not used to them - they mix easily with the junior categories. I think that's where they have trust - more than with the qualified nurses.

Potential loss of the secondary gain of distance created by their status may also therefore be a factor contributing to their anxieties associated with providing comprehensive care.

Lack of containment at a structural level for comprehensive care

My observation of clinic activities revealed a bureaucratic and technocratic approach to work. There were strict codes of conduct and rules as well as

standardised procedures for patient care. Work times were strictly adhered to, with nurses displaying anxiety if they were requested to work one minute into their tea or lunch breaks. Furthermore, they each, without fail, took their allotted quota of sick leave per month. This appeared to operate on a rotational basis and was taken on Fridays when the clinics were not so busy and when they had in-service training.

Furthermore, there were rigid divisions between enrolled, assistant, registered and senior nurses in management positions. The more junior nurses performed the routine functions such as giving injections and issuing contraceptives, whereas the professional nurses diagnosed and prescribed up to schedule 4. Decision making was centralised with nurses not having the autonomy to make independent decisions. In the context of primary health care nursing this was experienced as frustrating by one nurse as they needed to plan community interventions if necessary. According to this nurse:

> You have got to plan with your supervisor, if you can't do that you don't see yourself doing the things that you want to do in your work

and

> This year we have never had any meetings with our supervisors but we have been saying...

Moreover, I observed that evaluation of nurse performance was based on daily records which measured quantity as opposed to quality, diagnosis as opposed to understanding, and drugs administered as opposed to care provided. No space was allocated to record interventions other than medicines administered. Nurses were thus not evaluated according to the principles underlying comprehensive primary health care but rather on how well they provided biomedical care.

In addition, I observed that initiative was not rewarded. In fact, the one psychiatric nurse who attended the reorientation and training programme and initiated a similar programme in another area was relocated from his position in community psychiatric services to a psychiatric ward as his initiative was perceived as threatening to his superiors. As he indicated in the focus group interview:

> (There are) no incentives, no rewards, nothing. If you do this you're going to get that... they're (management) always at meetings... we are the ones in the front-line, all the workload and things, they come to us. They just sit there in the chair and put pressure on us workers.

When the participants were asked in the focus group interview what was the effect of this management style on them, one response was as follows:

> You are not appreciated enough... you lose interest, you are de-motivated, you are not given any chance to continue.

I interpreted my observations as reflective of a culture of sub-ordination which was borne out by the following comment by a nurse in the focus group interview:

> They are sticking to the culture of old nursing when they know that there's the one who is superior, then you cannot say anything.

Consequently, I found that the nurses generally showed little initiative or enthusiasm for new projects unless they were instructed to become involved. An example of this was their poor attendance of the consultancy sessions which followed the reorientation and training programme. They were asked to

organize these sessions themselves and were not instructed to participate by their superiors.

From a psychoanalytic perspective, the bureaucratic organization of nursing at the primary level of care was understood to contain anxieties associated with nursing. This was achieved through promoting a task centred biomedical approach to patient care which relieves nurses from the anxieties associated with comprehensive care. A task centred approach to nursing care was, in fact, identified by Menzies (1960) as serving as a defence against anxieties associated with patient-centred care in hospital settings, and appeared to serve the same function at the primary level of care.

Furthermore, the bureaucratic organization and management of the health care system has led to a culture of subordination. According to Stokes (1994), such a culture is characterized by a basic assumption mentality of dependency, which serves to relieve primary health care nurses of anxiety associated with responsibility, but at the same time stifles initiative and autonomy as is illustrated from some of the above excerpts. While this approach to management may be concordant with a task approach to patient care, it is inimical to the provision of primary health care which requires that nurses take responsibility for the health care needs of the community that they service.

At a structural level, the organization and management of primary health care was thus found to be uncontaining of comprehensive care. In this regard, nurses were not provided with the necessary support or incentives to provide such care. Moreover, while they were imbued with the responsibility of providing for the health care needs of the communities they serviced, they had insufficient authority to carry out these responsibilities. This was experienced

as frustrating by at least one nurse who attempted to take on this responsibility.

As has been suggested by Menzies Lyth (1991), institutions also affect the personality structure of their members. In this regard, a typology that emerged in relation to my observations of nurse attitudes towards their patients was that they generally adopted a paternalistic attitude towards their patients, even after the programme, with one nurse bordering on being authoritarian. This finding has been corroborated by Jewkes et al. (1998) as well as Mgoduso et al. (1992) and, as discussed in Chapter Five, may be attributed, in part, to the bureaucratic organization of nursing, where authority is derived entirely from one's position in the hierarchy. Given that primary health care nurses were placed at the end of a long chain of command, it was therefore not surprising that they had a need to exert authority over their patients. From a psychoanalytic perspective this may be interpreted as the internalization of the aggressor and displacement of aggression onto the patient. While it may function to relieve primary health care nurses of some of their feelings of frustration, it is not, however, facilitative of comprehensive care which requires an empowering relationship.

A secondary gain that parental and authoritarian attitudes towards patients provides for nurses, may also be that, as with status, these attitudes function to create distance. This makes it more difficult for patients to talk about their social and psychosocial problems with the nurses, or to reveal their understanding of their problem. As discussed, distance serves to contain some of the anxieties that nurses have in relation to dealing with psychological and psychosocial problems.

It is clear from the above that at a structural level, the organization and management of nursing was structured to promote a biomedical task oriented

approach to patient care. As such, it was uncontaining of comprehensive care, serving, in fact, to contain anxieties associated with such care through the promotion of biomedical care. It is thus clear that one cannot intervene with only one aspect of the system. In this regard, reorienting primary health care nurses towards the provision of comprehensive care thus needs to be accompanied by a restructuring of the health care system in order to ensure containment of such care.

Lack of containment within the macrocontext for comprehensive care

As illustrated by the following excerpts from interviews with the nurses, there was general agreement that patients expected and demanded medication and would shop around at clinics until they were given some. Furthermore there was the perception that the introduction of free health care had exacerbated these expectations.

> All the same they need to be consoled - and you give them a panado[6] - they don't accept going out just like that. Not unless it's a well educated person - they do understand - those you can tell them anything ... they come from the Waterfall clinic where (they get) education and advice - they are not given anything - the following day they are here - you do the same thing - tomorrow they will go to Botha's Hill.

and

> They are not interested in being told how to prevent diarrhoea or to treat diarrhoea at home. They want to come to the clinic for medication. You know why, they go to B clinic for diarrhoea, the nurse in B clinic will tell them how to make this home-made thing, she (the patient) won't be satisfied, the very same day she will take a bus to another clinic and then when you ask (and they will say) no I went to B clinic, they didn't give me anything... I want medication. But if they were

[6] Panado is a commonly used analgesic in South Africa which contains paracetamol.

> paying R2,00 they wouldn't be doing that. It's because services are free so they are abusing.

From the patients interviewed, I did indeed find that patients did not expect comprehensive care. While psychosocial problems may have been raised with the nurses, a typology that emerged was that patients didn't expect nurses to help them with such problems which were of a 'personal' nature. To quote from an interview with a patient:

> There is not much they can do. I have told them before, but they said that I must just ignore them (her children abuse alcohol). Anyway this is a family problem.

These expectations on the part of patients for biomedical care were understandable in light of the history of health care services in South Africa which have emphasized biomedical care. As a result patients have been socialized into expecting biomedical care, and in this way, the external environment is not supportive of the provision of comprehensive care either. In the face of expectations for biomedical care, from my observations and interviews, patients did, however, appear to appreciate and find helpful empathy and advice on emotional and/or psychosocial problems. On being interviewed after her consultation with a nurse, the patient in the following excerpt, who had recently lost her husband, indicated that she felt she had been helped because she had received medication and 'counselling' for her bereavement. From a professional point of view, the nurse did not in fact provide counselling, but her empathy and advice were interpreted as such by the patient when interviewed afterwards.

> *Nurse*: Do you have asthma?
>
> *Patient*: No I have never been told that. I think I cried too much.

Nurse: I see. What was wrong with your husband ?...Was your husband sickly?

Patient: No, there was nothing wrong with him - he was poisoned (she cries).

Nurse: Don't cry too much mama, or you will be sick. Your blood pressure is much better now, but if you cry too much it will go up. You need to accept what has happened. God will help you and your children.

Furthermore, the nurses complained that the new policy of free health care had increased patient numbers especially with very minor health problems which were previously treated by patients themselves. This increase in patient numbers was understood to leave less time for patient consultations and thus less time to deal with psychological and psychosocial problems. To quote from a focus group interview with the nurses:

> They come complaining, this one has got a rash, this one is coughing, this one has got worms, so you find that the clinic is just full of people... if services were not free, they wouldn't be bringing such minor ailments.

In light of these findings I suggest that the primary health care nurses felt uncontained by the broader macrocontext which was perceived as hostile to the provision of comprehensive care. Furthermore, in relation to the macrocontext, I suggest that they also used schizoid splitting as a defence for the anxieties generated by the need to provide comprehensive care. In this regard, they located the problem with the provision of comprehensive care within the macro-context, more specifically with the patients, who they suggested did not want such care; and with the new policy of free health care, which left them with less time to provide comprehensive care.

6.4 Third research question: What factors impede the transformation of the health care system to being supportive of a comprehensive discourse of care?

The factors mediating the provision of comprehensive care by the nurse participants discussed in the previous section highlighted the need for a restructuring of the health care system to be supportive of comprehensive care. The purpose of the fourth objective of the study was thus to develop an understanding of issues understood to impede the transformation of the health care system to being supportive of comprehensive care. The emergent themes were derived from specialist interviews with key informants in managerial positions as well as three focus group interviews with psychiatric nurses.

Through the process of analysis which has been explicated in Chapter Four on methodology, and using the conceptual framework discussed in Chapter Five, the following emergent themes were conceptualized as factors impeding the transformation of the health care system to being supportive of comprehensive care at the primary level.

Role of biomedical ideology in containing anxieties associated with dealing with psychological and psychosocial problems

At an individual level, the hegemonic hold of biomedical ideology was reported by all interviewees to still pervade the health care system from senior management at national and provincial levels to personnel who interface with patients. This is understandable in the context where a large number of personnel were inherited from the previous government, under which health care was organized in favour of tertiary hospital centred care. Furthermore, as discussed in Chapter Five, health care personnel have historically been trained and socialized to provide biomedical care.

It was suggested that this entrenched biomedical ideology was at the root of many of the problems being experienced in attempting to shift towards comprehensive care at the primary level. As suggested by one manager at national level:

> The orientation is still the main thing... (we're) looking at a goal where people won't just be looking at mental health in terms of the mentally ill people, but they'll be looking at mental health in terms of every ill health... every ill health does have a mental health component. Each case needs to be handled in such a way that there should be empathy- we should be able to give a little bit of counselling to a cancer patient, HIV positive person, etc. We should be able to look at people more holistically - we shouldn't just give counselling to schizophrenics, the bereaved, etc. We are looking at mental health as introducing a recipe for looking at a human being holistically.

From a national perspective, the orientation of provincial heads was noted by all interviewees at this level as playing a particularly important role in impeding transformation as suggested by the following quote:

> ... need more support from provincial heads in terms of integration - their orientation is a problem.

The orientation of provincial heads is regarded as particularly important given that constitutionally in South Africa, provinces have jurisdiction over health and cannot be dictated to by the national office. Furthermore, as pointed out by two interviewees, the provincial heads, as leaders of the health care system in their provinces, ultimately establish the culture within their institutions as well as the ideology on which the health care system is based. To quote one interviewee:

> So much comes down to the individual and the person in power and their particular orientation - whether policy gets implemented is very dependent on having the right individual in place.

This sentiment is supported by the literature, with Kets de Vries and Miller (1991) indicating that strategy, structure and organizational culture are all influenced by the personality of the top manager. The biomedical orientation of the leadership in KwaZulu-Natal was reported to be particularly problematic by managers from within this province. This perception is further corroborated by a study on the conflicts within the provincial health department (Bhagwanjee, Petersen & Moodley, 1997).

From a psychoanalytic perspective, the hegemony of biomedical ideology, even in the face of policy imperatives demanding a shift in emphasis to comprehensive primary health care, can be understood, at one level, as playing a role in defending health care providers from the anxiety associated with having to deal with associated illness problems. This anxiety was identified as a factor mediating the capacity of primary health care personnel to provide comprehensive care in the previous section. In this regard, given that many associated illness problems are poverty related, understanding the presenting complaint purely from a disease perspective relieves health care providers, in the first instance, of feelings of anxiety and guilt associated with their own material well-being and class position in relation to their patients. Secondly, it relieves them of feelings of impotence in the face of social problems which are much more complex to address and cannot be 'cured' through medication.

As suggested by critical medical anthropologists (e.g., Waitzkin, 1991), holding onto biomedical ideology thus relieves health care providers of

anxiety associated with the responsibility of having to address the causes of ill health, which in many instances in South Africa are poverty related and linked directly to the political economy of society. It thus benefits health care professionals who are either drawn from the middle class or have a newly acquired middle class status.

Furthermore, at a managerial level, a health care system focused on the provision of targeted technical interventions, characteristic of selective primary health care, e.g., immunization campaigns, is likely to be far more successful at achieving targets than one that strives towards the provision of comprehensive care which, as discussed in Chapters Two and Three, has a developmental agenda. While lip-service is paid to the need to transform the health care system towards one which is supportive of comprehensive care, there is little evidence of this on the ground.

Until anxieties associated with the provision of comprehensive care are contained, transformation of the health care system to be supportive of such care is likely to be resisted. Furthermore, biomedical ideology was promoted and maintained by both the dynamics and the organization and structure of the health care system as the following two themes illustrate.

Anxiety over loss of specialist status

Associated with the hegemony of biomedicine within the health care system was a striving towards specialization which was reported by eight interviewees as being a barrier to integrated comprehensive care. To quote:

> Training of medical personnel is very hospicentric... specialists provide the models that everyone strives after... everyone strives towards specialism.

Resistance to integration on the part of psychiatric nurses was identified and understood to derive from an anxiety on their part that they would lose their specialist status if integrated into primary health care as illustrated by the following quote from a psychiatric nursing manager:

> Status is affected ... that's why when this thing started some of the nurses considered leaving the services ... in fact some left.

Furthermore, when different models of integration were explored in the focus group interviews, the approach to integration that was favoured was the one adopted in the Western Cape province, where one nurse in each clinic, preferably psychiatrically trained, was identified to provide the follow-up care for all the chronically mentally ill patients. This interpretation of integration would mean that, while psychiatric services would be provided at primary health care clinics, the benefits of 'specialization' would, however, still be maintained.

One of the benefits of retaining specialist care for the chronically mentally ill, as reported in the focus group interviews, was that primary health care nurses generally had a negative attitude towards psychiatric patients. It was suggested that this, together with high patient loads and staff shortages, would lead to inadequate care of psychiatric patients and thus compromise continuity of care. In support of this sentiment, Schierhout (1998), in a review of 23 studies comparing integrated services with other models of care, indeed found that users of integrated programmes received less information compared to users of a dedicated service, and that for 'special' populations like psychiatric patients, retaining a degree of specialization ensured a better quality service. This information has since been incorporated into the framework for the delivery of mental health care in KwaZulu-Natal. It is suggested that a primary health care nurse, preferably with psychiatric

health care clinics was cited by one interviewee as being a major problem. Within the context of these dynamics, it is not surprising therefore that psychiatric personnel displayed anxiety at being subsumed by primary health care, and thus resisted integration.

Role of bureaucracy in impeding transformation

The management style, particularly at senior management level, was reported by all interviewees at provincial level to be highly centralized. To quote:

> So much talk about devolution of responsibility but there has not been much - it is still very centralized.

All the interviewees at provincial level felt that this had slowed down the transformation process. To quote:

> Problem is a lack of authority to implement the plan - nobody wants to give us written permission to do what we have to do.

This corroborates the findings of a previous study in KwaZulu-Natal (Bhagwanjee et al., 1997), in which centralization of decision making was reported to slow down the transformation process.

The lack of authority of mental health coordinators appeared to be a problem across all provinces. Coordinators of mental health in all the provinces were reported to lack the authority to implement policies developed at a national level. This was particularly problematic given that, as already mentioned, under the new dispensation in South Africa, provinces have jurisdiction over

health and ultimately decide on implementation of national policies in terms of provincial resources and needs. To quote one interviewee at national level:

> Human resource issues at provincial level is a major problem as you don't always have coordinators who embrace the understanding of the national policy and many of them are junior and don't have the clout within the province to implement.

The lack of authority of provincial mental health coordinators to implement national policy imperatives has been echoed by Flisher et al. (1998), who found, inter alia, that the structural arrangements for the coordination of mental health care, the level of seniority of the mental health coordinators, as well as their level of expertise and skills, affected the ability of the provinces to transform mental health services.

From a psychoanalytic perspective, while interviewees complained of a lack of authority to transform the mental health care system, the bureaucratic management style may also have functioned to relieve them of the anxiety accompanying such authority. As suggested by one interviewee:

> People want to know what they must do and they need an instruction, and they need some-one to give them that instruction.

Stokes (1994) suggests that a bureaucratic management style encourages a culture of sub-ordination where there is a preoccupation with status and hierarchy as the basis of decision making. Furthermore, there is a dependency on the leader to make decisions, relieving staff of anxiety associated with responsibility. This culture is therefore understood to contain

anxieties. In the face of this, resistance to change is a common experience (Stokes, 1994).

Furthermore, through schizoid splitting the blame for the lack of transformation could be placed with centralized management and the bureaucratic organization of the health care system, thus allowing district managers to retain a sense of self-idealization. As Stokes (1994) suggests, in this process, staff sacrifice, however, their autonomy which ultimately leads, at an individual level, to a sense of stagnation and burnout.

Role of the macro-context in impeding transformation

As was found in the investigation of factors mediating the capacity of primary health care nurses to provide comprehensive care following their participation on the reorientation and training programme, this investigation likewise found that patient expectations for biomedical care was also perceived as a barrier to the transformation of the health care system. To quote from one interview:

> Patients (are) socialized into expecting medication (but) they are not educated enough about medicine. Some of them don't comply with a treatment regime, others clinic hop and get medicine from a number of clinics which they mix together and still others use free medicine at clinics as a form of income generation. The success of this kind of trade is upheld by African culture which doesn't question the credentials of the healer.

In addition, policy developments in other sectors were also understood to have impacted on slowing down the transformation of the health care system. These include budget cuts imposed as a result of economic policies which

curtailed social spending between 1994 and 1998; as well as social redress requirements.

Budget cuts have indeed been found to impact on the resources available for health care (Bhagwanjee et al., 1997). Furthermore, in KwaZulu-Natal specifically, social redress and the amalgamation of the ex-KwaZulu Department of Health with the ex-Natal Provincial Department of Health and ex-National Health Department were reported to have resulted in individuals being placed in positions of seniority who were perceived to not always have the necessary skills to adequately perform the task requirements of their jobs. To quote one interviewee:

> Problem has been transition and amalgamation - we have lost some key people and people have been appointed who are not equipped to do the job.

There is no doubt that issues in the macro-context impinge on the transformation of the health care system towards a system which would be supportive of a comprehensive discourse of care. From a psychoanalytic perspective, locating the blame for the lack of transformation within the macro-context may, however, also be interpreted as functioning to relieve participants of the anxieties associated with such a transformation, using schizoid splitting as a defense.

6.5 Conclusion

The findings of this study have shown that in relation to the first research question, the reorientation and training programme effected a shift towards comprehensive care by the nurse participants in varying degrees. In this

regard, there was both an intra- and inter-subject variation on the indicators of comprehensive care in the post assessment.

In relation to the second question, which was concerned with developing an understanding of the factors mediating the capacity of the nurse participants to provide comprehensive care, my findings revealed that a number of anxieties, many of which related to a lack of containment for comprehensive care by the health care system, mediated their capacity to provide comprehensive care. The need for a transformation of the health care system towards being supportive of comprehensive care was therefore indicated.

The development of an understanding of factors impeding the transformation of the health care system thus constituted the second phase of the study and formed the focus of the third question. The findings pertaining to this question suggest that a paranoid schizoid position characterizes the health care system, whereby primary health care is accorded an 'underdog status'. This was understood to reinforce the idealization of biomedical hospital-based and specialist care while at the same time serving to contain anxieties associated with comprehensive care. While not dismissing the important role played by biomedicine in health care, structural reorganization of the health care system to support a comprehensive approach which acknowledges the role played by other factors in ill health is indicted.

In the following chapter I provide an integration of my findings from the three studies and question whether, under the current global and national context, it would be possible to close the gap between policy and praxis with regard to imperatives for comprehensive integrated primary mental health care.

CHAPTER 7

A DISCUSSION AND INTEGRATION OF MY FINDINGS

7.1 Introduction

In order to provide a comprehensive and integrated understanding of the issues involved in facilitating a shift towards a comprehensive discourse of care at the primary level, I have, in this chapter, integrated the findings of the investigations related to my three research questions reported on in Chapter Six. This integration is located within the overarching theoretical framework for organizational change provided by the Tavistock Clinic (Obholzer & Zagier Roberts, 1994), discussed in Chapter Five.

My research has demonstrated how the health care system is structured and organized to support and maintain biomedical care, thereby containing anxieties associated with the provision of comprehensive care. As such it acts as a social defence system, a concept originally developed by Menzies (1960), in the development of her understanding of how the organization and management of nursing served as a defence system against the anxieties generated by nursing care. More recently, Van der Walt and Swartz (in press) have used this concept to understand the defence system employed by public health nurses in tuberculosis clinics in South Africa. A social defence system was defined by Menzies (1960) as a collusive interaction or agreement between members of an organization, which often occurs at an unconscious level, and which comes to be understood as representing reality for both old and new members.

In this regard, my research has shown how, through the process of schizoid splitting, primary health care is attributed an underdog status. This functions to both relieve health care providers of the anxiety associated with comprehensive care, as well as promoting the idealization of biomedical, and especially specialist care.

Given this dynamic, it is not surprizing, therefore, that primary health care personnel strive towards the provision of biomedical care. Efforts at reorienting health care personnel towards the provision of comprehensive care, as conceptualized in Chapter Three, will thus not bear fruit unless the system is restructured in support of comprehensive care.

7.2 The need to restructure the health care system in order to support the provision of comprehensive care

At the epicentre of efforts to restructure the health care system in support of comprehensive care is the need to contain anxieties associated with such care. My research has shown that, at the interface between the primary health care nurse and patient, are many anxieties which need to be contained if comprehensive care is to be provided. In the first instance, anxieties around competence to deal with illness related problems emerged. As discussed, the training of nurses has not engendered in them the necessary skills to work in primary health care settings, nor to understand illness as a social, biological and cultural construct as conceptualized in Chapter Three. These findings concur with a recent study by Nolan, Murray and Dallender (1999) in the United Kingdom, where they found that practice nurses complained of a lack of skills to deal with psychological problems. They were found to be reluctant to get too involved with clients psychological problems in case they uncovered problems they would not be able to cope with.

While my study found that the reorientation and training programme served to contain some of these anxieties related to competence, other anxieties related to the provision of comprehensive care still prevailed. In this regard, many of the problems which present at the primary level of care in South Africa are poverty related and, as such, generate feelings of anxiety and guilt in nurses in relation to feelings of impotence in the face of these problems. Furthermore, in my study I found that these feelings were exacerbated when distance was lacking, particularly geographic distance, which makes it difficult for nurses to escape community needs, and thus renders them vulnerable to burn-out.

While a measure of distance may serve to contain some of these anxieties, as suggested by Van der Walt (1998), support was also found to be a crucial issue in this regard. In addition to skills and a measure of distance, primary health care nurses require support at both an emotional and technical level. Caring for illness related problems demands emotional labour. In order to provide such labour, nurses need to be emotionally contained themselves. Obholzer (1994), in fact, suggests that the absence of such support is expressed through illness, absenteeism, high staff turn-over and low morale.

Dealing with associated illness problems thus requires that nurses have the necessary support to provide such care. While comprehensive primary health care has a development agenda which should address the social etiology of illness, there are very few multisectoral development initiatives to support such an agenda. In the absence of such initiatives, the burden of dealing with poverty related illness problems thus falls on the primary health care nurse, and ultimately threatens her own material well-being.

Furthermore, while the development of such initiatives may be regarded as part of the work of primary health care nurses, their training and the bureaucratic organization and management of primary care nursing militates against the initiative required for such work. In the first instance, as already mentioned, they have been trained to take instructions from doctors. Secondly, the bureaucratic organization and management of nursing creates a culture of dependency which stifles autonomy and creativity. Thirdly, although given the responsibility of caring for community health needs, nurses felt that they lacked the authority to do so, and received little recognition for such interventions.

I thus found that the structure and organization of the health care system did not provide containment for anxieties associated with the provision of comprehensive care. In effect, it worked against the provision of such care. In the first instance, nurse performance was only measured on indicators of biomedical care, there being no incentives for the provision of comprehensive care, which includes the need for emotional labour. Emotional labour has historically been the unpaid vocation of women (James, 1989). I found this pattern to be mirrored within the health care system, where nurses, who are mostly women, were expected to provide emotional labour with little recognition or reward.

Furthermore, status and position in the health care system has historically been associated with more specialist care, with male dominated medical specialization located at the top of the hierarchy. Primary health care nursing is not regarded as a specialty, and is thus located at the bottom of the hierarchy. Furthermore, there are very few incentives for primary health care compared to specialist care. My analysis, in fact, revealed a dynamic whereby, through schizoid splitting, primary health care nursing was

attributed a negative status to such an extent that it was used as a form of punishment for poor performance by nurses.

Through the process of projective identification, primary health care nurses appear to have taken on this projection, reflected in their need to continuously improve their qualifications, and in their striving towards acquiring specialist status.

A further status-related anxiety that emerged was related to the nurses' apprehension that the provision of comprehensive care would serve to further compromise their status within the health care system. This anxiety emerged particularly in relation to the culture-centred orientation of comprehensive care. In this regard, they were found to display anxiety at incorporating such an approach into the nurse-patient relationship. This anxiety was understood to be a product of the perceived 'backward' status of traditional healing within the health care system. This resulted in a fear on their part that they would be regarded as 'backward' themselves if found to engage in a culture-centred approach in their consultations with patients.

Furthermore, as suggested in Chapter Three, at the epicentre of the development agenda of comprehensive primary health care is the need for a more equal and empowering relationship between nurse and patient. In this relationship, the patient should no longer be a passive recipient of care but play an active role in the healing process. Resistance to a culture-centred approach was interpreted from the perspective that it threatened the power and status that nurses wield in their own communities.

The need on the part of nurses to protect their power and status was also found by Seedat et al. (1992) to be a problem in their attempts to introduce psychological interventions into primary care. They found that such

interventions threatened the status of nurses, primarily because they required that patients shift from being passive recipients of care to active collaborators. To quote:

> "The demand psychological interventions make on clients to accept responsibility for healing themselves and thus becoming active, demanding (participation) in the healing process, is threatening to the medical hegemony because it conflicts with passivity and acquiescence encouraged by western medicine" (Seedat et al., 1992, p. 188).

This need to hold on to power and status within their communities should be understood, in the first instance, as a reaction formation to the history of oppression that black African nurses have had to endure under the apartheid system (Jewkes, 1998; Marks, 1994). It presents in the form of authoritarian and parental attitudes towards patients and is highly problematic as it is inimical to the empowering relationship on which comprehensive care is based.

Furthermore, these attitudes need to be understood within the context of the hierarchical structure of the health care system in which primary health care nurses are placed at the end of a long chain of command (Mgoduso et al., 1992). Their need to exert their power and status over their patients was thus also understood in relation to the process of internalization of the aggressor and displacement of aggression onto their patients.

In order to redress the anxiety associated with the loss of power and status accruing from comprehensive care, structural changes within the health care system are necessary. In this regard, a restructuring of the health care system from the existing paranoid schizoid position whereby primary health

care carries the burden of the negative aspects of health care to a depressive position, whereby this responsibility is shared, needs to be implemented.

While this restructuring process would need to address the underlying anxieties associated with this paranoid schizoid position, it would also need to be accompanied by a restructuring of the organization of the health care system so that primary health care is attributed more status than was the case at the time of this study. To quote one of the specialist interviewees:

> (We) should be inverting the triangle, giving generalists status in the health care system...we need to give them incentives for working at primary care level...the best managers should be at primary level care.

7.3 The need to challenge the bureaucratic organization and management of the health care system

My analysis also highlighted the role of the bureaucracy in slowing down the transformation of the health care system. In this regard, while on the one hand, participants complained of a lack of authority to implement changes, they simultaneously laid the blame for the lack of transformation on senior management, reflecting a process of schizoid splitting. As Stokes (1994) suggests, bureaucratic organizational formations generate a culture of sub-ordination which is highly resistant to change.

Furthermore, as suggested by Merton (1957) bureaucratic organisational formations produce in people a bureaucratic personality which is characterised by timidity, conservatism and technicism. Nurses were found, in this study, to display such characteristics. In this regard they were generally found to 'work to rule', and displayed little initiative or enthusiasm for new projects.

As discussed, this is inimical to the provision of comprehensive care which requires autonomous thinking and creativity.

Le Roux (1996), using Giddens' theory of structuration, in fact identified the role of the bureaucracy in slowing down transformation as one of three central forces retarding social and economic transformation in South Africa. (The second was concerned with the inability of the economy to provide a surplus for government expenditure, and the third with the impact of historical and global conditions beyond the control of the state which may impede social and economic development).

In response to the role of the bureaucratic organization and management of the health care system in slowing transformation, the following possibilities are suggested: (i) decentralization of management; (ii) a shift towards a 'human relations' management approach to nursing; and (iii) utilizing the private sector to achieve some of the goals of a comprehensive integrated district-based mental health care system.

With regard to the first possibility, decentralization of managerial responsibilities has occurred quite successfully within health and welfare systems in other parts of the world. For example, a shift from bureaucratic administrative structures to more locally accountable and responsible managerial regimes have been evident in the United Kingdom, the Netherlands and Sweden (Milewa, Valentine and Calnan, 1998).

In South Africa, while decentralization of the management of the health care system is one of the hallmarks of the district health system approach (Pillay et al., 1998), implementation is, however, slow, with regional managers complaining of a lack of authority to implement the district health system (Bhagwanjee et al., 1997).

With regard to the second possibility, while a human relations management style has been criticized for being a new form of surveillance and control (Hollway, 1991), it has nevertheless proved to be effective in increasing worker commitment and autonomy, both of which are necessary attributes for primary health care nursing. This requires proactive and entrepreneurial qualities on the part of management so that they can provide leadership and coordination as opposed to supervision and discipline (Walby et al., 1994). This would promote operational flexibility, an entrepreneurial ethos amongst health care providers, and greater responsiveness to the needs of local populations, all being important qualities for the realization of comprehensive primary health care.

Finally, opening the provision of certain services to tender from both public and private sector bids has also been a successful strategy to improve productivity levels in some public sector departments, notably, within the Ministry of Transport. I suggest that the introduction of public-private partnerships into the health care system may increase efficiency and is not necessarily at odds with the development approach to comprehensive primary health care. One way to ensure that implementation is informed by the principles of comprehensive primary health care would be to include these principles as criteria for tenders.

While these suggestions have emerged in response to the role of bureaucracy in slowing down the shift towards a comprehensive discourse of care, they may, however, also have broader applicability to the transformation of other sectors of society as well. Bureaucratic organizational formations are considered particularly problematic in South Africa given that existing bureaucrats have either been inherited from the apartheid system and may therefore be resistant to change, or they are new, having very little

experience in managing state resources. In this regard, high levels of inefficiency and corruption have, for example, been found to characterize the KwaZulu-Natal Health Department since the inception of the democratic government in 1994 (Bhagwanjee et al.,1997).

7.4 The need for containment within the macro-context

The macro-context was also blamed for the lack of transformation. As suggested, locating the blame for the lack of comprehensive care within the macro-context (budget cuts, increased patient numbers and patient demands for biomedical care), was interpreted as relieving health care providers of the anxieties associated with transformation, using schizoid splitting as a defence.

With regard to patient expectations, I suggest that a reorientation of the populace may emerge over time if a comprehensive discourse of care is consistently provided. This hypothesis is borne out by experiences of the integration of psychological counselling into primary care settings in other countries, such as in the United States and United Kingdom, where primary care patients were reported to find counselling an acceptable alternative to medication (Arean & Miranda, 1996; Corney & Jenkins, 1993).

Furthermore, with regard to increased patient numbers and lack of time, I suggest that the provision of mental health care at the primary level may not necessarily be more time consuming. Glied (1998), for example, in a study which assessed the effects of practice characteristics on the diagnosis and treatment of mental health problems in primary care in the United States, found that median visit duration only had a small, statistically insignificant effect on the rate of diagnosis and treatment of mental health problems.

Practice style was found to be a more important determinant of diagnosis and treatment of mental health problems.

It is my view, however, that the key problem with regard to the macro-context lies in the hegemony of biomedical ideology. As has been shown, at a structural and dynamic level, the whole health care system is geared to promote biomedical care. To quote Scott (1992):

> "This (biomedical) ideology ... may also have to be challenged ... The perspective of ... health practitioners need to be adjusted so that it includes the forest, as well as the individual trees that form it" (p. 340).

Given the inextricable links between biomedical ideology and the dominant capitalist political economy as discussed in Chapter Three (cf. Waitzkin, 1991; Singer, 1986), the possibility of making inroads into shifting the dominant biomedical ideology towards one which is more accommodating of comprehensive care, is, however, limited. Baum et al. (1995) suggest, in fact, that a shift towards comprehensive care is not possible under the current global economy which favours market economics and economic growth and profit margins at all costs.

Furthermore, South Africa's current economic policy of Growth, Employment and Redistribution (GEAR) has been widely criticized on the grounds that its emphasis on deficit reduction targets with associated reduced government consumption targets, and to a lesser degree, repayment of foreign debt, is at odds with the Reconstruction and Development Programme (RDP).

> "It is widely thought that GEAR implies a macroeconomic constraint that will undermine progress towards equitable and

> developmental social service delivery. A question often asked is: how can RDP goals be achieved if public spending has to be cut?" (Donaldson, 1997, p. 448).

While GEAR has served to fast track the development of a black middle class, its capacity to address the problem of poverty and development in South Africa has been questioned as it relies on a trickle down redistribution; prioritizes development in areas which have a competitive advantage; and benefits the emergent black middle class (Meth, 1998). Hence the problem of unemployment and concomitant poverty still pervades South African society, with 30-40% of the economically active population being unemployed (Van Rensburg, Kruger & Barron, 1997).

Within this socio-economic environment, the shift towards a comprehensive discourse of care at the primary level presents an enormous challenge. In the first instance, GEAR does not provide the necessary macro-economic development context to contain anxieties around feelings of impotence to assist with poverty related illness problems. It is therefore not surprizing that primary health care nurses were found to latch on to the victim blaming discourse of biomedicine as it served to contain these anxieties by locating the responsibility for ill health within the individual. Furthermore, as discussed in Chapter Three, biomedical ideology promotes middle class aspirations, which association with biomedicine provides. Moreover, the success of government departments is measured using quantitative measures, e.g., number of clinics built, as opposed to the quality of the service provided, therefore providing little incentive to the Health Department to focus on the need to shift the discourse of care.

7.5 A personal reflection

The bulk of my dissertation falls within what Smith, Harre and Langenhove (1995) term the new paradigm in psychology. This new paradigm is understood to emphasize:

> "understanding and description more than measuring, counting, or predicting; meaning rather than causation or frequencies; interpretation rather than statistical analysis; language, discourse, and symbols rather than reduction of data to numbers; holistic rather than atomistic perspectives; particularities rather than universals; cultural context rather than context-free perspectives; and subjectivity as well as objectivity" (Pedersen, 1999, p. 4).

Given that the hallmark of this new paradigm is a contextual understanding of human behaviour, where the validity of subjective as well as objective evidence is recognized, it is apposite that I, as the researcher, reflect on the subjective experience of the research process. Furthermore, a key aspect of ethnography is that it acknowledges the role played by the researcher in the research process (Hammersley et al., 1983).

In this spirit of reflexivity it is important to consider the implications of my different roles in this study and how I attempted to deal with them. I adopted multiple roles, namely, that of facilitator of the reorientation and training programme, evaluator and researcher. These roles are very powerful ones, which bring with them a power imbalance, which was further exacerbated by my being a psychologist. Psychologists are 'specialists' in mental health care and are therefore attributed more status within the health care system than primary health care nurses, or even psychiatric nurses who fall beneath them within the hospital hierarchy.

While I attempted to reduce this power differential as a facilitator by adopting adult education methods and problem-based learning in the reorientation and training programme, this was more difficult to achieve in the roles of evaluator and researcher. My attempts in this regard included emphasizing the need to understand the factors which impeded the capacity of the nurse participants to provide comprehensive care, as opposed to evaluating their actual ability. Furthermore, I had hoped, through this process of encouraging self reflection on their part, to empower them to address these factors. An example in this regard was trying to encourage them to agitate for changes to the existing system, such as their daily record forms.

On reflection, these attempts proved to be largely fruitless and, while this may be a product of the culture of sub-ordination which characterizes nursing, it may also be indicative of a lack of motivation to actually provide comprehensive care on the part of the nurse participants. In this regard, changes in the system would mean that they could no longer place the blame for not providing comprehensive care on external factors.

I also found that once the nurses had completed the reorientation and training programme, they were reluctant to attend consultation sessions. At times I felt as if they were doing me a favour! Given that their attendance of the consultation sessions was not enforced by the nursing service manager, their lack of motivation may be interpreted as once again reflecting the culture of sub-ordination and accompanying lack of initiative on their part.

It may, however, also be interpreted as reflecting resentment towards myself and the reorientation and training programme itself. In this regard, I was the bearer of more anxiety for them. I was asking them to provide comprehensive

care while the system remained the same, and did not provide them with support or incentives to do so.

Furthermore it may also reflect a pattern, which I observed, whereby nurses were continually trying to improve their qualifications in order to gain more status and recognition within the health care system. They appeared more concerned with acquiring certificates than actually improving the quality of the care they provided. Following this line of thought, as they had already received their certificates, there was really no point in attending the consultation sessions.

These reflections reinforce, to some extent, some of the findings of my study. In this regard, the need for power and status emerged as a key issue in understanding the participants' responses to the reorientation and training programme.

As was argued in Chapter Three, the establishment of a more equitable empowering relationship between health care provider and patient is regarded as being at the epicentre of the development agenda of comprehensive primary health care. It follows, therefore, that unless the need for power and status on the part of primary health care nurses is addressed, comprehensive care will remain at the level of rhetoric. My study has shown that a reorientation programme on its own will not address this issue. What is needed, inter alia, is a restructuring of the health care system so that it empowers primary health care providers. Only when empowered themselves, will primary health nurses be in a position to empower others.

CHAPTER 8

CONCLUSION

8.1 Introduction

This dissertation is unique in that it has interrogated the gap between policy principles demanding a shift towards comprehensive integrated primary mental health care and the implementation of these principles. In this concluding chapter, I provide, in the first instance, a brief overview of the conceptual arguments made in Section One of this dissertation. Secondly, I extract some key issues that emerged from my research study in Section Two that require consideration if the gap between the policy principles for comprehensive integrated primary mental health care, and the implementation of these principles, is to be narrowed. Thirdly, I discuss some general processes which emerged from my study which I believe can be recontextualized and generalized to other contexts, having broader applicability to transformation of society as a whole. Finally, I discuss some limitations of my study, from which I synthesize some suggestions on how to take my work forward.

8.2 Summary of conceptual arguments

In Chapter Two, I provided an overview of the transformation of mental health care in low-income countries and South Africa specifically. This overview indicated a disjuncture between policy principles and implementation. While there was consensus on the need to decentralize

mental health care as well as provide care for both serious and common mental illness and psychosocial problems, implementation has, however, been characterized by an emphasis on caring for the seriously mentally ill. Furthermore, an add-on approach was typically adopted as the mechanism for integrating mental health into primary health care. This was characterized by a psychiatric component being added to the workload of primary health care personnel.

In Chapter Three, I argued that this approach to integration was a product of the reformist nature that characterizes the implementation of primary health care. I argued that while comprehensive primary health care promotes a development agenda, this remains at the level of rhetoric. Implementation is characterized by a selective technicist approach to prevention, with care remaining largely biomedical in orientation. Furthermore, the biopsycho-social model was criticized for being an inadequate model for the promotion of comprehensive care. In fact it has been challenged for promoting biomedical ideology into other spheres of life.

Psychiatry, being compatible with biomedicine, is thus easily appended to an existing biomedically dominated system. A comprehensive approach to mental health care is not. I argued that for comprehensive integrated primary mental health care to be achieved, a shift towards a comprehensive discourse of care at the primary level would, in fact, be required. Furthermore, I suggested that a critical cultural approach to healing developed within medical anthropology, be adopted at the primary level of care. I argued that this approach would provide a broader, more appropriate theoretical model of healing for a comprehensive discourse of care than the biopsychosocial model.

Following this conceptual argument, my study, reported on in Section Two, was concerned with developing an understanding of how a shift towards a comprehensive discourse of care could be achieved. In pursuit of this aim, I embarked on, inter alia, in-depth case study research complemented by broader specialist interviews. As discussed, case study research is valuable in that it explores general processes and how they impact on a specific case. While not providing conclusive evidence on the factors which mediate the shift towards a comprehensive discourse of care, this approach offered useful and intensive analysis of these factors. As such, it provided in-depth information on the issues that require consideration in order to close the gap between policy imperatives for comprehensive integrated primary mental health care and the implementation thereof.

With respect to the analysis of my data, I used the model of organizational change developed by the Tavistock Clinic as a broad framework of analysis. As discussed, this model adopts open systems theory in conjunction with psychoanalytic concepts in understanding organizational functioning.

8.3 Key issues for consideration in narrowing the gap between policy principles for comprehensive integrated primary mental health care and the implementation thereof.

My study revealed that reorientation programmes for primary health care personnel towards the provision of comprehensive care, as suggested by Van Niekerk et al. (1997), are insufficient to facilitate a shift towards a comprehensive discourse of care. Primary health care personnel cannot be expected to provide comprehensive care when no containment or support is provided by the system for such care.

My study in fact revealed that the health care system is structured and organized to defend against anxieties associated with comprehensive care, and as such, functions as a social defence system. This is achieved through the promotion of biomedical care. In addition to training and socialization in biomedical care, there are no incentives for comprehensive care, and no support mechanisms in place to contain anxieties associated with such care. Instead, idealization of specialization is promoted through a reward system which attributes status to specialist and hospital-based care, while primary health care is attributed an underdog status.

In this regard, a dynamic appears to operate whereby, through the process of schizoid splitting, primary health care, which is supposed to provide comprehensive care, is attributed negative images. This was interpreted as functioning to promote the idealization of specialist biomedical care through splitting off those aspects of health care which are less likely to show positive results, and which instill in health practitioners anxieties associated with a sense of impotence, as opposed to omnipotence, which biomedicine provides.

Secondly, comprehensive care threatens to erode the power and status that primary health care nurses enjoy through their association with biomedicine, both within the health care system as well as within their communities. Their need to hold on to this acquired power and status, was understood as a reaction formation to both the apartheid legacy of oppression of black African nurses, as well as the negative images attributed to primary health care within the health care system, where primary health care nurses are placed at the bottom of the hierarchy.

Thirdly, the bureaucratic organization and management of the health care system also emerged as an impediment to the promotion of comprehensive primary health care. In this regard, a task centred biomedical approach to

care was promoted, instilling in primary health care personnel a bureaucratic personality which is antipathetic to primary health care which requires autonomy and creativity.

In light of these findings, the need for the transformation of the health care system to support a comprehensive discourse of care was thrown into sharp relief. Given that a more equitable and empowering relationship between primary health care provider and patient was considered central to the development agenda of a comprehensive discourse of care, a key issue identified in this restructuring process was to attribute more power and status to primary health care provision.

The probability of such a transformation occurring is, however, limited by the macro-context. In this regard, biomedicine operates as an ideology which both maintains and is maintained by the macro-context. Through understanding illness as disease, it detracts from the social and cultural construction of illness. Furthermore, the hegemony of biomedicine is maintained by the macro-context through global and national socio-economic policies which reward technical feasibility and cost-effectiveness as well as middle class status, which may be acquired through association with biomedicine.

8.4 Some general processes that have broad applicability to understanding social transformation

In terms of general processes that emerged from this study, which have broad applicability to policy analysis, and which may contribute to understanding social transformation, I have extrapolated the following issues.

In the first instance, the importance of unpacking the meaning of policy principles at a conceptual level emerged as a key process which needs to be undertaken to inform implementation. As was demonstrated in Chapters Two and Three, this has clearly not happened with respect to policy principles underpinning the transformation of the mental health care system in South Africa. While these policy principles demand the integration of *comprehensive* mental health care at the primary level, a trajectory has emerged where the integration process has been conceptualized from an add-on perspective. I argued, in Chapter Three, that this interpretation will not achieve comprehensive primary mental health and that a shift in the discourse of care at the primary level would, in fact, be required to achieve these policy principles.

Secondly, my research has demonstrated the value of in-depth case study research as a method for providing intensive analysis of issues that require consideration in order to effect the implementation of policy principles. Using the shift to comprehensive integrated primary mental health care as an example, this study has shown how these principles may remain at the level of rhetoric unless intensive analysis is undertaken to understand the issues that need to be addressed in order to facilitate their implementation.

Thirdly, this study has highlighted the importance of using a comprehensive framework for analysis, such as that provided by the Tavistock model of organizational change, in order to ensure the development of a comprehensive understanding of issues that require consideration to effect transformation. In this regard, the need to understand anxieties operating at an unconscious level and defenses built up to contain these anxieties need to be understood and addressed for transformation to occur. Furthermore, the importance of understanding the problem of transformation from a systems

perspective, and the issues that function to maintain the system at all levels, has also been emphasized.

8.5 Limitations of this study and the way forward

The limitations of this study include, in the first instance, the fact that while the use of case study research allowed for an intensive analysis of the issues at hand, this method does, however, limit the generalizability of my findings. In this regard, although triangulation research was conducted, it was bounded to one sub-district. A comparative case study approach using more than one sub-district would have been useful to increase the validity of my findings.

Secondly, while contributing to the development of an understanding of the issues that impede transformation towards a comprehensive discourse of care, it should be noted that the findings of this study are a product of my interpretations of the emergent data. In this regard, the interpretation of the emergent was informed by 'foreshadowed problems' which included the Tavistock model of organizational change, explicated in Chapter 5. Another researcher may have given different interpretations to the emergent data. It is for this reason that qualitative research within the interpretive tradition requires reflexivity on the part of the researcher as to their role in the research process (Hammersley et al., 1983). Furthermore, my findings remain in the realm of theory.

My research therefore raises a number of empirical questions. For example, in order to provide more conclusive evidence to support my findings, a restructuring of the health system along the lines suggested would be required, and its impact on care provided at the primary level, evaluated. (I

suggest that systematic intervention in selected districts may prove to be a useful way forward.) In this regard, field trials to assess the cost efficiency and feasibility of the reoriented clinical encounter would be necessary. Of particular interest would be to evaluate the role played by the horizontalizing of the clinical relationship, given that power inequities have also characterized traditional healing relationships.

Thirdly, as discussed, given the links between biomedical ideology and capitalist social relations which dominate the world economic order, a transformation of the health care system to one which is supportive of a comprehensive discourse of care is limited by the macro-context, but, I suggest, not impossible. In this regard, intensive advocacy and activism, championed by social movements, would be required to create an awareness of how primary health care, as it is currently constituted, does not represent a radical departure from health services provided under the apartheid system, except that they may now be more accessible. I suggest a two pronged approach whereby intensive lobbying occurs with relevant government departments and directorates at national and provincial level as well as at a grass-roots level.

It would be important that this process highlights the reformist nature of primary health care, whereby, as with family medicine, it provides the opportunity to extend the influence of biomedical ideology into other spheres of life such as work, relationships and sexual behaviour. Most importantly in this regard, through its victim-blaming discourse, it detracts from the role played by existing socio-economic relations in the development of ill health, locating the responsibility for health and 'healthy' behaviour within the individual.

My findings, in their own right, are, however, unlikely to spur the development of social movements around the need to restructure the health care system to be supportive of a comprehensive discourse of care in the foreseeable future. Mental health care and its integration into primary health care is not a priority in South Africa, nor internationally.

In order to attract the attention required to create such social movements, my findings would need to be linked to a high profile issue/s. The development of social movements around issues represents one of the key strategies for addressing the social and structural roots of mental ill-health within community psychology (cf. Rappaport, 1977), and have proved effective around the world in facilitating structural change.

A good example, is provided by the social movement that has emerged around violence against women and children in South Africa which has reached epidemic proportions. In this regard, 1.6 million people were estimated to have been raped in 1998 (South African Law Commission, 1999). Through public demonstrations and media exposure, a heightened awareness of the unequal gender relations which underpin oppression and violence against women has been raised, and has resulted, inter alia, in some of the strictist legislation against violence against women and children in the world.

HIV/AIDS provides a good example of how my findings could be linked to a high profile issue. It has also reached epidemic proportions in South Africa, and particularly in the province of KwaZulu-Natal, where 26.92% of women attending ante-natal clinics tested HIV positive in 1997 (Department of National Health, 1998).

Furthermore, recent research by Campbell et al. (1999), has highlighted the need to understand HIV/AIDS prevention programmes from a development

perspective as opposed to current initiatives which emphasize behaviourist and biomedical approaches. Behaviourist approaches have been shown to be unsuccessful; and an AIDS cure is still not in sight (Campbell et al., 1999).

Campbell et al. (1999) demonstrate, through their research on HIV/AIDS in the mining industry, that at the heart of the HIV/AIDS epidemic in South Africa, are a range of social and psychosocial circumstances which require consideration. To quote:

> "Social factors include: economic factors, working conditions and gender dynamics. The link between these social factors and unsafe sexual behaviour is mediated by a range of psychosocial processes, in particular low levels of self-efficacy, knowledge and beliefs that compete with health educational messages, and masculine identities" (Campbell et al., 1999, p. 1634).

Central to the HIV/AIDS epidemic in South Africa is thus a lack of psychological and political empowerment. Even with the new democratic dispensation, people do not have a sense of control over their lives, which adds fuel to the spread of HIV/AIDS. To quote Campbell et al. (1999):

> "The more people feel that they are in control of their lives, the more they are likely to take measures to protect their health...A perceived lack of control in one's life in general may extend to a sense of lack of control of one's health, and the increased likelihood of unsafe sexual practices" (p 1635).

Furthermore, Campbell et al.'s (1999) findings also highlight, inter alia, the need for HIV/AIDS prevention programmes to take into account indigenous cultural belief systems which may not be consistent with the HIV/AIDS

educational messages located largely within the biomedical paradigm. To quote:

> "The majority of HIV/AIDS intervention strategies are strongly associated with the western biomedical approach - which may play a limited role in a mineworker's perception of health and healing. More care needs to be paid to traditional cultural beliefs and practices" (Campbell et al., 1999, p. 1635).

In light of this understanding of the HIV/AIDS epidemic in South Africa, the need for a development approach to health promotion is thrown into sharp relief. Such an approach represents a shift from persuading people to change their behaviour to enabling them to do so (Campbell et al., 1999). The need for such an approach is supported by Bhagwanjee (1999), who suggests that an alternative health promotion project is required, which, to quote:

> "... intervenes at both macro and micro levels with the explicit intention of empowering the marginalised and the poor in order to produce fundamental shifts in the balance of power in society" (p. 97).

This demands an empowering development agenda which is concerned with addressing the socio-economic relations of society which restrict behavioural choice. Furthermore, the need to take local perceptions of health and healing into consideration has also been highlighted.

Given that primary health care personnel act as 'gatekeepers' to the health care system and are first in line to be confronted with STDs, the need for primary health care personnel to adopt such a development approach to HIV/AIDS prevention is paramount. As discussed in Chapter Three, such an

approach is central to a comprehensive discourse of care. As my research has shown, such a discourse of care will, however, require a restructuring of the entire health care system.

Furthermore, the education, training and socialization of primary health care personnel would need to equip them with the necessary orientation and skills to function as 'boundary spanners'. This term was coined by Rappaport to refer to the roles and functions of psychologists working within a community psychology paradigm (Swartz, 1996). Given that community psychology is concerned with addressing the social and structural roots of mental ill health, it demands that, in addition to providing traditional mental health care services, community psychologists are required, inter alia, to play the role of advocate, activist and facilitator. Primary health care personnel, providing a comprehensive discourse of care, would need to take on these roles as well.

8.6 Closure

In closure, this study emerged out of the need to understand the issues at play in closing the gap between policy and praxis with regard to comprehensive integrated primary mental health care. Given that the provision of primary health care is characterized by a selective technicist approach, which adheres to a narrow biomedical view of ill health, I have argued for a fundamental shift in the discourse of care at the primary level of care. Following this argument, my research has problematized this shift, throwing up issues which are of concern, not just for the integration of mental health care, but for the broader implementation of comprehensive primary health care in South Africa. What is clear, however, is that an academic problematization of this shift will remain just that, unless it is also accompanied by advocacy and activist work.

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APPENDIX 1

THE REORIENTATION COMPONENT OF THE TRAINING PROGRAMME

Introduction

The reorientation module for the primary health care nurses covered the following:

- Policy principles underlying the shift towards a comprehensive, community-based and integrated mental health care system in South Africa.
- A framework for the provision of district-based mental health care and the implications for the roles and functions of primary health care nurses at district level.
- Nursing ideology and its subsumption by the medical system.
- Problems with the add-on approach to integrating mental health care into the primary health care system and the need for a comprehensive approach to patient care.
- A framework for assessing problems from the perspective of comprehensive care.
- Skills for comprehensive care, which include the comprehensive care relationship, the process of comprehensive care as well as the problem management model.

While there was some formal input in terms of information and theory, as far as possible the didactic approach was interactive, drawing on the principles

of adult education and problem-based learning. In this regard, the learning process relied heavily on utilizing and reflecting on the experiences of the participants.

Policy principles underlying the shift towards comprehensive, community-based and integrated primary mental health care.

In order to orientate the nurses towards their role in a decentralized and horizontalized mental health care service, an overview of the policy principles underlying care for mental health and substance abuse problems in South Africa as discussed in Chapter Two, was provided and interrogated.

Of particular importance was the development of a common understanding of the concepts of *integration, comprehensive care* and *community-based care.* With regard to *integration*, a brainstorming exercise was adopted in order to develop an understanding of how the participants viewed this concept. In this respect, there are different models of integration. The 'supermarket model', for instance, makes provision for a number of health services to be provided at a clinic, offering a 'one-stop' service (cf. Lenneiye et al., 1998). While facilitating comprehensive care under one roof, it can, however, be criticized for perpetuating vertical services. For instance, psychiatric patients, under this system, would still see psychiatrically trained nurses for mental health problems as opposed to generalists albeit at primary health care clinics as opposed to psychiatric clinics. It does not, therefore, promote the concept of comprehensive care as conceptualized in Chapter Three.

With regard to *comprehensive care*, a brainstorming exercise was also undertaken to establish the participants views on this concept. Within primary health care it is generally viewed from a biopsychosocial perspective, with an emphasis on prevention, promotion and multisectoral development.

Given the critique of the biopsychosocial model provided in Chapter Three, the nurse participants were alerted to the reductionist and reformist nature of the biopsychosocial model. Furthermore, the need to also consider culture in the construction of illness was introduced. These issues were, however, unpacked more fully in the section covering problems with the add-on approach to the provision of primary mental health care and the need for an alternative theory of understanding illness and healing at the primary health care level.

With regard to *community-based mental health care*, Caplan's (1964) concept of preventative psychiatry was used as a framework to demonstrate the development of a community-based mental health care system. Caplan (1964) conceptualized prevention as occurring at three levels, namely, tertiary, secondary and primary prevention. Tertiary prevention is concerned with ameliorating long term symptoms of the psychiatrically ill through rehabilitation. Secondary prevention is directed at reducing the prevalence of disorders through early detection and treatment, while primary prevention focuses on reducing the incidence of disorders through addressing the causes of mental illness both at a reactive and proactive level. Reactive primary prevention refers to increasing the ability of individuals to cope with stressful life events, while proactive primary prevention addresses the stressors in the environment.

Integrated primary mental health care would demand that primary health care nurses engage in primary, secondary and tertiary prevention activities. Given that primary prevention deals with the causes of a problem, a number of possible models of primary prevention were also explored. These included the population welfare model, population adjustment model, social action model and social ecology model (cf. DeWild, 1981). The first two are models of reactive primary prevention, while the last two are models of proactive

primary prevention. Participants were asked to critique these models and to suggest which would fit best with comprehensive primary health care, which stresses community development and empowerment of individuals and communities to have control over their health.

A framework for the provision of district-based mental health care and the implications for the role and functions of primary health care nurses at district level.

Given that primary health care nurses were understood to play a central role in the integration of mental health into primary health care, there was a need to orientate them to their roles and functions in relation to the restructuring of the mental health care system at district and provincial level. To this end, the framework for the restructured mental health care system discussed in Chapter Two (see Table 1, p. 33), was provided. Given that it has been discussed in greater detail in Chapter Two, only those aspects pertaining directly to the roles and functions of primary health care nurses are discussed here.

Within this framework, primary health care nurses were located at one of two points of entry into the health care system, namely, tier 2, which is the level at which the primary health care clinics are located. Tier 1 is the community level of care and is comprised of health care workers and other care-givers who conduct home visits, such as community health workers, auxiliary workers and social workers; as well as health care providers within the community who are not formally linked to the health care system, e.g., traditional healers, ministers of religion, non-governmental organizations and even teachers. While ideally primary health care nurses should be in a position to move between tiers 1 and 2, they rarely conduct home visits due to their workload at tier 2.

Given their location at one of the two entry points into the health care system, primary health care nurses function as 'gatekeepers' to the system. With regard to mental health care, as gatekeepers they are envisaged to provide primary, secondary and tertiary prevention. In this regard, of central importance would be their role in the early identification and management of common mental health and behavioural problems and referral of more serious cases, as well as the provision of follow-up medication and psycho-education for the chronically mentally ill on their return to the community level of care.

Nursing ideology and its subsumption by the medical system

The nursing system was explored in relation to how the holistic ideology of nursing care has been eroded by biomedicine and the bureaucratization and technicalization of health care. In this regard, nurses were asked to explore the disjuncture between how they understood illness and how they practiced primary health care. The subordinate nature of nursing sub-culture was also explored in relation to how it was supportive of a task oriented approach to patient care, which in turn acts as a buffer against the stress of having to provide emotional labour required in the care of patients' emotional and social problems (Menzies 1960).

Emotional labour demands that the health care provider brackets, or puts aside, his/her own emotions or issues in order to provide a caring environment which facilitates healing in the patient. In the absence of active support and recognition, it can, however, lead to 'burn-out' which manifests in the alienation of the health care provider from the patient, low morale and absenteeism.

In this regard, nurses were asked to explore their feelings towards their patients and their work, and to identify the basis of these feelings. The need for the organization of the primary health care system to be supportive of emotional labour was also emphasized, and participants were asked to identify issues within the primary health care system which inhibited their ability to provide emotional labour.

Furthermore, they were also asked to reflect on their need for status within their communities and within the health care system and whether this was played out at all in their relationships with their patients.

Problems with an add-on approach to the provision of mental health care and the need for comprehensive approach to patient care

Problems with simply adding a psychiatric component to the work of primary health care nurses as a mechanism for the provision of integrated primary mental health care was explored in relation to the dominant biomedical view within psychiatry. This was achieved through initially brainstorming the nurse participants' understanding of biomedicine and then comparing this to an illness understanding of mental health problems, which, while not excluding the disease process, also considers the role played by social, psychological and cultural factors in the construction of illness. The *role of culture* in the construction of illness was explored first.

In this regard, the importance of understanding a patient's explanatory model of illness was emphasized. Inadequacies of the psychiatric approach for facilitating comprehensive integrated primary mental health care were discussed in relation to the following.

In the first instance, psychiatry's disease orientation as well as its emphasis on labeling and categorizing mental illness was explored in relation to (i) how it fails to take into consideration the patient's explanatory model of illness (cf. Kleinman, 1987); (ii) how this neglect has been found to compromise the effectiveness of intervention (Kavanagh & Kennedy, 1992); as well as (iii) how it has been found to lead to problems with treatment compliance (Helman, 1994). To illustrate this point, examples of explanatory models of illness used by patients were extracted from the nurse participants. Furthermore, they were asked to draw on their experience and share examples of where treatment compliance had been compromised by a lack of consideration of a patient's explanatory model of illness.

The concept and need for culturally congruent care was then discussed. Culturally congruent care emphasizes the need to consider the subjectivity of the illness experience for the patient. Furthermore, the nurse participants were also alerted to the need to be critical of power relations underpinning cultural constructions of illness. In this regard, they were asked to reflect on who benefits from certain traditional cultural understandings of illness.

Leininger's (1988) three possibilities for culturally congruent care, namely, preserving the cultural orientation; negotiating some change in the cultural orientation; or repatterning the cultural orientation, were explored.

Cultural preservation encourages the continued use of traditional practices as long as they are harmless and/or helpful and are thought to encourage acceptance of less familiar treatment regimens. Negotiating some change in the cultural orientation involves the accommodation of identified needs of both traditional medical systems and biomedicine. Cultural repatterning involves persuading the patient to diverge from traditional healing practices if they are harmful to the patient or his/her family.

The need to ensure cultural safety, which is central to all these approaches, was, however, stressed. Culturally safe nursing refers to nursing practice which respects the cultural identity of a given cultural group and attempts to meet the needs of patients from this group, as opposed to disregarding and demeaning associated beliefs and practices (Polaschek 1998). Culturally congruent care thus demands that care provided is acceptable and reasonable to the patient (Kavanagh et al., 1992). With all these approaches, the need for the intervention to be negotiated rather than imposed, so that the patient is an active collaborator in defining acceptable, satisfying and meaningful care was further emphasized.

To illustrate the concept of culturally congruent care, the participants were asked to provide case examples, from their own experience, where culturally congruent care was applicable, and a discussion was held on which of the three approaches would be the most appropriate one to use. An example of where the third approach was deemed appropriate was in the traditional practice of treating epilepsy through blood-letting. Given the potential dangers involved in this practice, as well as the positive effects of treatment compliance with medication for epilepsy, cultural repatterning was therefore considered appropriate in this instance.

Psychosis provided an example of where the second approach was deemed appropriate. It is often understood as 'amafufunyane' within Zulu culture, which is understood within traditional Zulu medicine as the intrusion of alien spirits which need to be removed (Ngubane, 1977). In this instance, negotiating some change in the cultural orientation was considered appropriate given that traditional approaches for the treatment of psychosis are not generally harmful (Ngubane, 1977), but the patient would need to be persuaded to be hospitalized and/or take his/her psychotropic medication

simultaneously. In this instance, the needs of both traditional medical systems and biomedicine would need to be accommodated.

With regard to the *role of psychosocial issues* in the construction of illness, these were discussed in relation to the biopsychosocial model which underpins both psychiatry and primary health care. While this model raises an awareness of contextual problems, which may be associated with the presenting complaint, as discussed in Chapter Three, health care practitioners have been found to either ignore these issues, or to adopt a reformist, reductionist approach to dealing with them, in which specific interventions for specific problems, are implemented. Primary health care providers have been found to rarely engage with interventions that address the root causes of ill health (Baum et al., 1995), which in many instances in South Africa are poverty related. The nurse participants were asked to reflect on this in relation to their own interventions with patients who were suffering from obvious poverty related illnesses such as kwashiorkor, an illness resulting from protein energy malnutrition, which is still to be found in the KwaDedangendlale community.

With regard to mental illness specifically, the importance of considering the contextual nature of illness was illustrated by way of a discussion of the presentation of common mental health problems, which constitute the bulk of mental health problems at the primary level of care in South Africa and internationally (Freeman et al., 1997; Jenkins et al., 1998). The nurse participants were asked how these problems presented in primary health care settings and how they were commonly treated. Given that they present largely as physiological complaints in primary health care settings (Patel, 1998; Swartz, 1998) and are treated as such, the importance of inquiring about associated illness problems was highlighted.

Finally, the nurse participants were asked to review problems with the add-on approach to integrated primary mental health care and to make suggestions as to an alternative approach. In this regard, the need for a comprehensive approach to care which understands the interdependence of social, cultural, psychological and physical correlates of illness was stressed.

The case of Phumla cited by Segar (1997) was used to illustrate the need for an approach to care which would take into consideration the interaction between social, physical, emotional and cultural imperatives in the construction of illness. Segar (1997) conducted a three year ethnographic study of a young woman she called Phumla. Phumla lived in the former homeland of the Ciskei in South Africa and had returned home from Cape Town with her new-born baby after a breakdown in her relationship with her boyfriend. Her boyfriend refused to pay her maintenance and her mother was also battling financially. Phumla began to suffer from a variety of ailments including headaches, chest pains, stomach aches and indigestion, tiredness and memory loss, all common symptoms of depression and anxiety. For the three years that Segar followed her case, Phumla sought a variety of treatments which involved a great deal of money, effort and travel. She was unable to find relief for her symptoms and was given a variety of diagnoses which included ulcers, depression and amafufunyana. According to Segar (1997), while Phumla herself made the connection between her ailments and her broken love affair and subsequent financial difficulties, these problems were, however, never discussed with any of the healers she visited.

This case clearly demonstrates the need for the health care provider to understand the contextual nature of illness, including the subjectivity of the illness experience for the patient. The nurse participants were asked to reflect on their feelings towards the provision of such an approach to care in

relation to power relations with their patients, as well as the implications it would have for their roles and functions. With regard to the latter, as discussed in Chapter Eight, it would mean that they would be required to adopt a development agenda with respect to their work, taking on additional roles of advocate, facilitator and activist.

A framework for assessing problems from the perspective of comprehensive care

Katon et al.'s (1980) clinical social science approach for the provision of meaning centred care was adapted and used as a framework for assessing problems from the perspective of comprehensive care. It required that nurses assess patients on biological, psychological, social and cultural dimensions with the last dimension requiring an understanding of the patient's explanatory model of illness. If patients were found to hold traditional beliefs about the cause and course of their illness, nurses were encouraged to discuss these with their patients and to incorporate them into the treatment plan either through maintenance, accommodation or repatterning.

Furthermore, this model also required that nurses inquired about associated illness problems which may be either etiological or iatrogenic to the presenting problem but which would facilitate a diagnosis on psychological and social dimensions. Exploring associated illness problems was stressed as being particularly important for the provision of integrated mental health care in developing countries. This was in view of the fact that, as has already been mentioned, patients in these contexts have been found to somatize minor mental illness such as anxiety and depression which, as a result, are often misinterpreted as hypochondriasis (Helman 1994). Furthermore, these problems have been found to often be associated with social and psychosocial problems (Al Issa, 1995; Swartz 1998).

In addition to facilitating an understanding of the presenting problem on biological, psychological, social and cultural dimensions, incorporating a patient's explanatory model of illness into the formulation of the problem was also discussed in relation to how it could facilitate a shift in the nature of the power relations within the patient-healer relationship. Through inviting patients to participate in knowledge production on illness and healing, they would, for example, be encouraged to be active participants in the healing process as opposed to passive recipients of care. In this regard, nurses were encouraged to be reflexive in their approach to patient care, and to reflect on their own needs for power and status and how their approach to patient care may function to perpetuate a power differential in the healing relationship.

Once the presenting problem was understood on biological, psychological, social and cultural dimensions, nurses were encouraged to negotiate intervention with the patient. Leininger's (1988) three possibilities for culturally congruent care, viz., preserving the cultural orientation; negotiating some change in the cultural orientation; or repatterning the cultural orientation were explored as possible options in relation to negotiation.

As an exercise to illustrate how this could be done in practice, the nurse participants were asked to provide a case based on their experience, and develop an assessment of the problem from a critical cultural perspective which would take into consideration the role of biological, psychological, cultural and social issues in the construction of the illness. They were also required to make suggestions as to intervention. An example of a case used was as follows:

A 35 year old woman with four children of school-going age came to you complaining that her whole body hurt, her bones felt cold and that she felt faint. She also complained that she had no energy and thought that she was going to die. On checking her blood pressure, you also found that it was very high. She didn't go to work the day before and requested a letter putting her off work for the next three days. She was an unskilled factory worker and on probing indicated that her supervisor had been making sexual advances on her. She cannot leave her job as her husband had recently abandoned her for another woman, leaving her to take care of the children.

Skills for comprehensive care

The comprehensive health care relationship

In order to develop a common understanding of the relationship required to facilitate a critical cultural approach to care, the nurse participants were required to brainstorm the ingredients of such a relationship. The need for a non-threatening relationship to facilitate cultural safety was stressed. In this regard the patient needs to feel comfortable enough to reveal his/her understanding of his/her illness without feeling judged. Furthermore, Kavanagh et al. (1992) stress the importance of awareness, sensitivity and knowledge to facilitate culturally congruent care. In this regard, while sensitivity and awareness promotes empathy; knowledge of traditional health practices promotes understanding. Moreover, Katon et al. (1980) suggest that meaning centred care requires the health care provider to demonstrate warmth, empathy, persistence and be non-judgmental. These qualities concur with those identified by Truax et al. (1967) as being necessary for an effective therapeutic relationship, namely, accurate empathy, nonpossessive warmth, and genuineness. It follows, therefore, that these qualities would also assist

in encouraging the patient to explore associated illness problems with the health care provider.

In order to illustrate the qualities needed for a comprehensive care relationship, the participants were asked to volunteer to role play a typical interview using the biomedical approach. This was contrasted with a role play of an interview where a comprehensive approach was adopted.

Finally, the issue of privacy was discussed as an important environmental condition to facilitate a relationship which would promote comprehensive care. Primary health care clinics are often very crowded and have little privacy. In this regard, as an exercise, the participants were asked to think about what they could do to create an environment which would facilitate more privacy.

The process of comprehensive care

Given that comprehensive care requires that the nurse spends time initially understanding the problem from a biopsychosocial and cultural perspective, communication skills to facilitate this process were explored. These included active listening and micro-counselling skills to ensure that a problem is understood from the patient's perspective.

Following Ivey's (1994) model of the counselling process, the following factors which would facilitate exploration of the problem were explored:

- The nurse's own *non-verbal behaviour,* namely, the way that she sits, looks at, and responds to her patient should convey a sense of warmth, caring and interest.

- *Observation* of the patient's non-verbal behaviour, namely, that often patients have difficulty verbalizing what they are feeling and observation of non-verbal behaviour, such as their facial expression, tone of voice etc., can give the nurse some clues about their emotional state.

- *Open questioning,* namely, that the use of open questions such as how and what questions can bring out more information than closed questions.

- *Minimal encourages,* namely, verbal and non-verbal behaviours on the part of the nurse which would encourage the patient to continue talking.

The following skills which could facilitate understanding the problem were also explored:

- *Clarifying*, namely, that while it may be best to let the patient talk about his/her problem with as little interruption as possible, the nurse may, at times, need clarification on something and require the patient to explain some aspect of the problem in more detail to her.

- *Reflecting*, namely, commenting on the patient's thoughts, feelings and behaviours to help make the patient feel understood while simultaneously providing an opportunity for the patient to deny/confirm the nurse's understanding of the problem.

- *Summarizing*, namely, summarizing the problem for the patient to ensure that the nurse's understanding of the problem mirrors that of the patient's.

As an exercise to practice these skills, the participants were asked to role play a problem that they had, or that one of their patients had had and, using these skills of exploration and understanding, to make an assessment of the problem using a biopsychosocial and cultural framework.

Problem management

To assist the nurses to deal with psychosocial problems, which underpin the majority of common mental illnesses presenting at primary care level (Swartz 1998), the problem management model was explored. This model has been used extensively in South Africa for the training of lay counsellors (e.g., Sawyer et al., 1996; Sterling et al., 1995) and has been found to be extremely useful in empowering clients with materially based problems which are often associated with minor anxiety and depression (Swartz, 1998; Al Issa, 1995).

This model can help patients to decide on different ways to manage/solve a problem and to assist them to develop a plan of action to implement the solution or management plan. There are a number of steps involved:

- *Step 1* involves understanding the problem. This requires that the nurse utilizes the microcounselling skills outlined above to explore and understand the problem. Often a person comes with a large problem which may be more easily managed if broken down into smaller problems which need to be dealt with separately in order of importance.

- *Step 2* involves finding different ways to manage the problem. This entails encouraging the patient to think of different ways to manage the problem. The nurse may also make suggestions but should be careful not to give advice as this may create a dependency on her.

- *Step 3* involves deciding on the best way to manage the problem. This entails assisting the patient to decide on the best way to manage the problem. It is important that the patient makes the decision as he/she will consequently feel more empowered and in control of the problem. Furthermore, the decision should reflect the values of the patients and not those of the nurse. The patient should be assisted to look at the advantages and disadvantages of each option and then choose what he/she thinks is the best option.

- *Step 4* involves exploring different ways to act on the option chosen. This step involves exploring different strategies for putting the chosen option into action.

- *Step 5* involves deciding on the best plan of action. This entails looking at the advantages and disadvantages of the different strategies and choosing the best one.

- *Step 6* involves the patient carrying out the plan of action.

- *Step 7* involves monitoring and evaluation of the plan of action. The patient needs to return to discuss with the nurse how effective the action was and possibly repeat the process to deal with any new problems that may have arisen.

As an exercise to practice the use of this model, the participants were asked to use these steps to try to manage/solve the problem that they had explored with their partner in the previous exercise

APPENDIX 2

TRANSCRIPTS OF NURSE-PATIENT CONSULTATIONS OF SUBJECT 5 AND RATINGS OF TWO JUDGES

Transcripts of Consultations of Nurse 5 (Pre-Assessment)

1. Male Patient: (40-50 yrs)

Nurse: How do you feel today?

Patient: I feel much better today, I didn't sleep in my house. I thought the change would do me good.

Nurse: I see, you slept somewhere else?

Patient: I slept in my brother's house, we got hurt together but he is still in hospital. I had difficulty falling asleep.

Nurse: Do you feel better when sleeping in your brother's house rather than in yours?

Patient: I think it is better to sleep in my house.

Nurse: What is it that you felt might change if you are not in your house?

Patient: The coughing, it hurts and there is also some blood.

Nurse: It was good of you to bring your X-rays as I told you before. Oh, I see they included your old X-rays. Let's see. When did you take this one? Oh, it's from 1993. Is this when you started treatment for heart trouble? As you can see here your heart was still swollen. Let us see today's X-rays. Can you see here? Your heart is still swollen, but here it is much better, but you see these spots, they are your lungs and they saw these spots in King Edward and that is why they said you had T.B.

Patient: Oh, I see.

Nurse: What I will do is to send you to the doctor, together with this letter from K.E.H. He will then decide whether you should start your T.B.

treatment. Now come and lie here on the bed so that I can examine you.

(The nurse then asks the patient if he minds being examined with the researchers present - he says he doesn't because he will only remove his top clothing.)

Nurse: You didn't come with your wife today? Let us take your temperature now. I will use the armpit thermometer so you wont have problems breathing. Now, lie down and breathe... Put your clothes back on.

(Patient goes outside to cough.)

Nurse: Feeling any better now?

Patient: Much better.

Nurse: Let's have your arm, now, is it difficult to breathe? Okay, you can go to the doctor now so he can see you. Take this letter with you.

Researcher: Do you see everybody or just the returning patients?

Nurse: No, I see everybody who comes in here.

2. Male Patient: (35-45 yrs)

Nurse: Greetings

(She then explains about the researchers.)

Patient: I was supposed to come back on Thursday but I did not have the money so I came today.

Nurse: I see, why were you supposed to come back?

Patient: I was supposed to bring my spit in this bottle that they gave me and then have chest examinations.

Nurse: Did you bring your spit with you? Oh, I see, put it in your pack. I'll show you where to take it. When was it, last week? Oh, I see, on the 7th. How do you feel now?

Patient: It's coughing. I had a headache but the nurse gave me some pills for it and it is better now. Now it's only the coughing that bothers me.

Nurse: Is it a dry cough or is there something which comes out?

Patient: It is not dry.

Nurse: Have you ever had T.B?

Patient: No.

Nurse: For how long have you been coughing, weeks or months?

Patient: It comes and goes, you know. Sometimes we use traditional medicine.

Nurse: Does it help? I mean, using Zulu medicine?

Patient: Sometimes it helps and other times it doesn't.

Nurse: Can you tell me exactly for how long you have been coughing? Has it been a month?

Patient: If I count from the time I saw the mobile clinic, it is three weeks now.

Nurse: Are you still coughing?

Patient: Yes, more especially at night.

Nurse: Is it the cough that worries you?

Patient: Yes.

Nurse: You said you never had T.B. - anybody in your family with T.B?

Patient: No.

(A Doctor comes in with some X-rays.)

Nurse: Come this side sir, so I can examine you, open your chest up. Oh my, so much clothing. You did not want any cold coming near you today. Move closer now. Right -breathe in and out. There - put your clothes back on before you get cold. There is some noise in the upper part of your chest. I will show you where to leave the cough phlegm and then you will have to go for some X-rays and come back so we can see inside your chest. Come, let me show you where to go.

3. Female Patient (50-60 yrs)

Nurse: Come in mama. Sit here on the chair. Can you walk?

Patient: Yes.

Nurse: What happened?

Patient: My foot hurts.

Nurse: When did this start?

Patient: On Thursday.

Nurse: Were you hurt?

Patient: No, it just swelled up and it hurts.

Nurse: It just happened like that? It was not sprained or anything?

Patient: No, I just had this pain and ignored it and then my foot swelled up.

Nurse: How many days have passed since this happened?

Patient: Not too many days, and then my husband died.

Nurse: When did this happen?

Patient: He was buried on Saturday.

Nurse: Oh, shame. I sympathize. Do you take any pills?

Patient: Yes, I do for high blood pressure, but I still have some.

Nurse: I see. The problem is just your foot? You said it has been a week? Let us look at your foot. Can I remove your socks?

Patient: Yes.

Nurse: Can you move it like this (moving her foot up and down).

(Another nurse comes in wondering why there are so many people in the consulting room.)

Nurse: Let us check your blood pressure now. Do you take your pills? And do you have any left?

Patient: Yes sister.

Nurse: Is your chest okay? You sound like you have a problem. Can you come this way so I can examine it.

(Another nurse enters with some X-rays.)

Nurse: Do you have asthma?

Patient: No, I have never been told that. I think I cried too much.

Nurse: I see. What was wrong with your husband?

Patient: He was sick.

Nurse: Do you have grown up kids?

Patient: Yes, my eldest has a daughter who is now married. They are quite grown up.

Nurse: Was your husband sickly?

Patient: No, there was nothing wrong with him. He was poisoned. (She cries.)

Nurse: Don't cry too much mama, or you will be sick. Your blood pressure is much better now, but if you cry too much it will go up. You need to accept what has happened. God will help you and your children.

Nurse: I see here in your chart that you had problems with your chest and have received medication for it before.

Patient: Yes, I got some from the mobile clinic.

Nurse: I will take you to the doctor to see about your chest. Did the medication you got from the mobile clinic help before?

Patient: Yes.

Nurse: I will give you these pills for your chest. Take one in the morning and one in the evening, twice a day, and this mixture is taken three times a day, once in the morning, once during the day and once in the evening. It will help with your cough. These pills are for your pains, two in the morning, two during the day and two in the evening; and these work like an injection, take two in the morning and two in the evening. From the doctor you will go to the dressing room where the nurses will bandage you. You must come back on Wednesday so that we can check if there is any change.

4. Female Patient

Nurse: How are you today?

Patient: I am fine.

Nurse: What is your name?

Patient: (tells the nurse her name).

(Nurse explains the presence of the researchers.)

Nurse: What seems to be the problem?

Patient: My arm hurts and my whole body hurts. It started on Friday and I didn't go to work. My bones feel cold and I feel faint.

Nurse: When did this start?

Patient: Friday, in fact on Thursday when I woke up I couldn't move such that I didn't even go to work. Even coming here was very difficult.

Nurse: Oh, I see. You were not hurt but your arm just started hurting. Has this happened before?

Patient: Never, I am quite a healthy person. I work with no problems.

Nurse: Is any part of your body swollen?

Patient: No, it just hurts terribly.

Nurse: This never happened before? Did you work very hard on Friday?

Patient: No, I did not work that hard.

Nurse: Let us see your legs. Can you move them?

Patient: Yes, I can move them, it is just this pain. Can you write me a letter so that I wont have to go to work until Wednesday?

Nurse: We no longer write letters but only the clerks do them now. Why do you want to start working on Wednesday? Because you are not that seriously sick. What will the kids eat if mummy doesn't go to work?

Patient: I need energy sister. I thought I was going to die.

Nurse: Let me check your blood pressure... Let me see your tongue. It seems fine. Maybe you worked too hard, that is why you were hurting. I just

checked your blood pressure as you told me you feel faint. It is normal. I have checked your eyes and your tongue to see if you have enough blood in your system... that is how we can tell. All seems to be in working condition. I will give you some pills to help your body circulation. Take them after food three times a day. The clerk will give you the letter to say you came to the clinic today. Give him this card and he will help you. Be sure to take your medication.

Transcripts of Consultations of Nurse 5 (Post-Assessment)

1. Female Patient: (50-55 yrs)

Nurse: Hullo, how are you today? You have come with a young lady today.

Patient: Oh yes, I have brought her to the clinic. She has some problems with her ears.

Nurse: Come sit this side please. How can I help you today?

Patient: I have come to collect my blood pressure tablets and I am also coughing and have a headache.

Nurse: You are coughing, have a headache and your pills?

Patient: Yes.

Nurse: Do you have any problems with your pills?

Patient: Well, yes, I haven't seen anything wrong.

Nurse: Okay, and when did you start coughing?

Patient: This week as the weather got colder.

Nurse: This week? When exactly - Monday?

Patient: No, I was already coughing by Saturday. I think it was last week.

Nurse: I see, any phlegm?

Patient: Yes, I do have some.

Nurse: What colour?

Patient: Yellowish.

Nurse: Is there somebody in your family who maybe once had T.B?

Patient: My biological father once had problems with his chest.

Nurse: What about in your home, the family you are married to?

Patient: No, nobody has it.

Nurse: You said you have been coughing for a week?

Patient: Yes.

Nurse: Okay, I will check your blood pressure first and then your chest.

Patient: There is a lot of flu going around these days.

Nurse: Yes.

(The nurse checks her blood pressure and afterwards asks her to lie down to examine her chest.)

Patient: I also have some back pains sister. I think it is because of the cold. It hurt so much I feel like my backbone is going to break into two.

Nurse: Have you suffered from it before?

Patient: Yes, I have had it for a long time now.

Nurse: Did you have an accident or get hurt somehow?

Patient: No, but the first time I had it, it was like I had broken it.

Nurse: When was this?

Patient: A long time ago. I was still young.

Nurse: Have you ever seen a doctor regarding this problem?

Patient: Yes, I have and got some pills and rubbing ointment. It subsides for a while and then starts again.

Nurse: Okay, get dressed now.

Patient: Oh my, I skipped a button. I was wondering why it seems funny- the trouble with getting old.

Nurse: You old - never!

Patient: I am old sister. Sometimes you just get confused and see that you must be getting old.

Nurse: Your card tells me that the last time you came for your blood pressure medication was in February.

Patient: Yes, I usually go to the mobile clinic but unfortunately when it came I was away because I go around selling stuff to people.

Nurse: Where do you sell your goods?

Patient: I move around to wherever disability grants are being paid.

Nurse: Far away?

Patient: Yes, sometimes, and then I would lose out on my dates for medication. That is why I decided not to wait for the mobile clinic and just came here.

Nurse: Yes, I can see that it has been two months now.

Patient: Yes, but they were not yet finished.

Nurse: I see here that your blood pressure is a little high.

Patient: It is? Well, I had finished the lot.

Nurse: Yes, and that is why we can never stress enough the importance of continuing with treatment, making sure that you always have an adequate supply. Because when your blood pressure gets high you are susceptible to a number of different diseases, as you have been complaining about your back and your bones. You must really make sure that you come back on the days when we tell you to come back, even before if you see that you are running short. Don't wait until they are all finished.

Well as far as your chest is concerned, there doesn't seem to be anything wrong. It seems it is just a cold. I will give you some cough mixture.

Patient: Well, it does seem like a cold, because it is not worrying me too much. I do, however, have a problem with a constant heartburn.

Nurse: Do you ever notice what type of food causes you to have it? Because sometimes it can be caused by the food you eat.

Patient: It is difficult to say because it usually starts after any food, even after drinking tea sometimes.

Nurse: Do you have it now?

Patient: No, I haven't had anything to eat yet.

Nurse: I do not have the cough mixture here with me. Therefore you need to collect it from the dispensary. Do you know where it is?

Patient: Yes.

Nurse: These are your usual pills, one in the morning and evening. And you take one of these every day. And these will help with your heartburn, just chew them, one in the morning, daytime and evening.

Okay, and please try to remember your next visit for your medication. Bye.

2. Female Patient (32 yrs)

Nurse: Good morning, how are you?

Patient: I am not too well sister.

Nurse: Do not worry about this other lady, we all work together in health.

Patient: I have lower abdominal pains. Sometimes I can't even sleep at night. It feels hot and hurts in my back. I don't know but I am sure I am not pregnant, because I had myself sterilized.

Nurse: When did you have sterilization?

Patient: In 1993.

Nurse: You said your lower abdominal part hurts and your lower back as well?

Patient: Yes, sometimes I feel like pushing my back out when I am walking because of the pain.

Nurse: For how long has this been going on?

Patient: The pain started on Sunday. I had felt it before but on Sunday it came to a head. I just could not sleep on Monday and Tuesday as well.

I could have come sooner but I did not have money, even now it is thanks to my neighbour who took pity on me and brought me here.

Nurse: So, you have had this for a while now, but it became worse on Sunday?

Patient: Yes, I would have these pains but did not think it serious enough to need me to go to the clinic. But on Sunday - I mean, if I was pregnant I could have just gone to the hospital because it felt like I was in labour.

Nurse: The pain is like labour pains?

Patient: Yes, it is here in the front. It feels like there is something in here.

Nurse: Is that the only problem you have? Do you have any problem with your urine?

Patient: It hurts when I pass urine. I feel like jumping up and down when I do it. I also have a discharge. I even use a pad for it.

Nurse: I see. When did this discharge start?

Patient: On Sunday as well. I thought I was having my period because for the whole of April I didn't get my period until the morning of the 25th. It felt like I was getting my period but it then stopped and again on Saturday the 26th, it came back but by the following day it had stopped again, and it came back again on May 1st (on a holiday).

Nurse: How many children do you have?

Patient: Four.

Nurse: How old is the youngest?

Patient: Three, she will be four this year.

Nurse: Are you married?

Patient: No.

Nurse: Is your boyfriend having any problems, sexually transmitted diseases perhaps?

Patient: Well, I haven't heard anything from him because, well, I don't know how to explain this. I stay in his home because I have his children and

I cannot be a burden to my mother. Sometimes I get odd jobs but most of the time I am not working and my children are weak. They need to be near their father and there is nobody who could take care of them if I were to stay at my mother's house and let them stay with their father, because he is an orphan. Our living arrangement is that he has his own hut and I have mine. He brings women every now and again. Sometimes he may call me for sex but he does that rarely, like the last time I was with him was during Easter holidays, and before that we had had sex in January.

Nurse: He was intimate with you during Easter holidays, before that it was in January. Is he married to someone else?

Patient: No, I am the only wife he has. There is no-one else except for his string of girl friends. He has quite a number of them because even from the neighbourhood I can't even talk freely with anyone because people would tell me that I am a fool, for the person I am laughing and joking with had spent the night with him. He doesn't even discriminate in terms of age, young girls, ladies and even older women.

Nurse: Mmm.

Patient: And don't even get me started about where he works. I am even ashamed to go out of the house.

Nurse: You said that he has his own hut and you your own. Whose decision was that?

Patient: His, because he wanted to bring his girl friends home. I just stay with my kids.

Nurse: Do you like what he is doing?

Patient: No, I don't like it but there is nothing I can do.

Nurse: Mmm. What makes you not like it?

Patient: Well, I don't like it because I know that I should go back home as he tells me. The problem is that my mother is alone at home. I never had a father. I do not have a job, I would be a burden. The kids are quite grown up. They are at school and I haven't even paid for their fees

yet. He doesn't help with the kids at all, their education or food. I really do not know why I stay there.

Nurse: He doesn't buy food - you have to fend for yourself to find something to eat?

Patient: Yes, sometimes I do some washing for somebody and repair the mud walls of somebody's hut if they ask me. As I said, there really is no reason why I stay there. It's just that I do not want to be a burden. I even had to take my girl out of school. She is fifteen.

Nurse: Now, how does staying with him when he behaves like that make you feel?

Patient: It is only for the children, because they get sick when they are not in their home. As far as I am concerned, it hurts but there is nothing I can do but bear it. I don't say anything. He needs to see my presence in his home yard.

Nurse: I see. You haven't perhaps thought of what you might do to help yourself and the kids so that you don't do anything but witness his bringing his girl friends home?

Patient: Like what?

Nurse: Whatever it is that you think might help you.

Patient: There is nothing except perhaps if I were to get a job.

Nurse: What would you do if you got a job?

Patient: I would help support my kids, buy them food and send them to school.

Nurse: And where would you stay?

Patient: I would go back to my mother's house. Although my kids are a problem and I am forced to stay with them, I cannot leave them alone, because he has no parents and he works during the day and sometimes he doesn't even come home. Or maybe take them out of school I did that last year, took them out in June anyway - I had not paid by then because I had no job.

Nurse: You took them out because you did not have money?

Patient: I was leaving and also did not have money at the time and nobody to leave them with.

Nurse: Right now, where do you get food from?

Patient: The lady who brought me here helps me a lot. She has a similar last name as he does, although they are not related. She helps although she has to hide from him because he has mood swings and would just act as if you had a fight and not talk to you.

Nurse: Do you ever speak to your neighbours about the possibility of finding a job?

Patient: Yes, they try to help a lot, tip me off if somebody needs someone to do their washing, etc.

Nurse: Oh, I see.

(Interruption - a nurse comes in.)

Nurse: I am terribly sorry about the interruption. The fact that he brings girl friends home, does it not bother you more especially that you might get STDs?

Patient: I do think about that and I am afraid, especially about these incurable diseases.

Nurse: Is he aware of such a disease?

Patient: Yes, people tell him but he wont listen. The thing is that I don't know whether he uses anything with them or not.

Nurse: Does he use anything with you?

Patient: Nothing, he wont use anything with me.

Nurse: What would you like him to use?

Patient: I tell him that I need to collect a condom from the clinic but he says it is for the prostitutes and school kids.

Nurse: He says that! Have you ever collected one from here?

Patient: No, I have never taken it because he hates it. He once hit me up when I gave him one that I got from a friend. He said I had an affair. I just stay as I am because I know I have no lovers. You remember I

told you that the last time we had sex before the Easter weekend was January. Well, before that it was in February last year.

Nurse: You stayed all this time not being intimate with him and at the same time you were seeing him bringing girl friends home?

Patient: Yes, he doesn't even hide them. He does not care.

Nurse: He doesn't care. If you were to ask him to come here to have a talk with us, do you think he would agree?

Patient: No, he wouldn't - no way.

Nurse: Where do you come from?

Patient: From Embo area, near the school.

Nurse: Is it close to the mobile clinic?

Patient: Yes.

Nurse: Is he available during the week?

Patient: No, he is at work then and even on Saturdays sometimes he has to work. He is only home on Sundays.

Nurse: He does need to be educated about the use of condoms as you said that he likes women. This might put you in danger of being infected with a disease, if he were to meet a woman who is infected with a virus. You must try and talk to him and beg him to come to the clinic so that we can try and give him some advice about the use of condoms. Maybe the reason he is stubborn is because he does not have enough knowledge, he only knows what other people tell him and that may not be correct information anyway. Maybe if we were to sit down with him and have a talk he might listen.

Patient: I don't know. It is difficult because he does not talk to me at all. He does not have time to talk with me. Sometimes when I try to talk to him he would just leave the room.

Nurse: Aren't there any elders at home who can help you talk to him?

Patient: He does not have parents.

Nurse: Relatives?

Patient: He does have a sister but she does not like me and his relatives cannot talk to him.

Nurse: But if you were to go to his sister and sit down with her and explain the situation, don't you think that she might listen? Ask her to tell him to come to the clinic. Wont he listen to his sister?

Patient: No, he won't listen because she does not like me.

Nurse: Do you have a community health worker close to your house?

Patient: Yes, I do - Mrs Madima Blose.

Nurse: Do you think that he would listen to her if she were to speak to him?

Patient: She could try. Maybe because he knows that she is something in the community, he might listen to her.

Nurse: Come to this side now. I want to examine you. Lie down here on the bed. What is your boy friend's name?

Patient: Mfanyana S'thole.

Nurse: Who decided on sterilization? Was it you or him?

Patient: He did. He was drinking a lot at that time and he felt that he won't afford another baby.

Nurse: Okay, get dressed now. Is he your only boy friend?

Patient: Yes.

Nurse: I want you to take this pill now. Do you have a bag?

Patient: Yes.

Nurse: Okay, this is what I found from my examination. You have a sexually transmitted disease. You have a pus-like discharge. I am sure you have seen it.

Patient: Yes.

Nurse: This discharge does not appear on its own accord but it is an infection you get from sleeping with an infected person. In order for treatment to be effective, we need both of you to be treated. That is why I asked you whether you can get a community health worker to help you talk to him, as you said he won't listen to you. But I do think that he might

listen to Mrs Blose since she is an elder. Because we do need to treat him and not him alone, but his girl friends as well. Do you understand?

Patient: Yes, I hear you. Now does this infection mean that I am going to die and leave my children alone?

Nurse: No, I did not say that you have an AIDS virus. What you have can still be cured. Do you understand?

Patient: Well, it's because AIDS is what we hear about these days.

Nurse: No, with an AIDS virus there has to be a blood test before we can say that you have it. I cannot just look at you and say you have it. What I am talking about is the most common infection that you can get from a man who has some sort of an infection himself, the type that you can still treat successfully. I do not mean you have AIDS... Do you understand?

Patient: I don't know, you might be hiding the truth from me sister.

Nurse: No, haven't you heard how you can find out that a person has it?

Patient: I have heard.

Nurse: And what have you heard?

Patient: They say you need a blood test.

Nurse: Yes, that is true. I can't just look at you and tell you that you have AIDS. You need a blood test and they will test it and only then will they tell you whether you have it or not. Is that clear?

Patient: Yes.

Nurse: Why are you smiling like that, hey?

Patient: No, its nothing I am just...

Nurse: Okay, here is your medication. There are ten of them in this container. I want you to go home, have something to eat and take all of them, one time.

Patient: All of them?

Nurse: Yes, all of them. Only these, the white ones, do not mix them up. And with these coloured ones, you take two of them only, once a day. Is that clear? And this is for your problems with your urine, take one spoon in the morning, during the day and evening. Follow it up with a glass of water. And you have to take this card to your boy friend. He will have to use it when he does decide to go to the clinic or doctor. I also have condoms for you but I don't know whether to give them to you because you said he hits you if you give them to him.

Patient: It is better to have them around sister.

Nurse: What are you going to do about the card, because he might fight with you and say you are the one who is sick.

Patient: Well, I know he won't admit that I got this from him anyway.

Nurse: I did not say that you got it from him. Don't go to him and say that, "they say you gave me a disease." He will hit you. What are you going to do about the card and condoms?

Patient: I am afraid that when I give him the card and tell him to go to the clinic, he will say that he is not sick. I don't know how I am going to explain this to him.

Nurse: You will tell him that you were at the clinic and they... Does he know that you are sick?

Patient: I told him.

Nurse: And what did he say?

Patient: He does not care.

Nurse: He did not tell you to go to the clinic?

Patient: No.

Nurse: Well, you will tell him that you went to the clinic and the nurses told you that you have a discharge and you both need to be treated so that you do not infect each other. Don't say that the nurses said you have an infection and you need to be treated for it. Just tell him that we said that you both need treatment because when you have sex and one of you has not been treated, you will infect each other.

Patient: Okay, I understand.

Nurse: Here is your card. I don't know whether you want us to contact the community health worker, if you are afraid to do it?

Patient: No, I can contact her myself because she lives quite close by.

Nurse: Okay, do not forget your medication. Do you still remember how to use it?

Patient: Yes.

Nurse: Okay, thank you and goodbye. If you have a problem, come back and talk with us and we will see what we can do.

3. Male Patient

Nurse: Hullo, how are you?

Patient: Quite well, thank you. And how are you?

Nurse: I am fine, thanks. How can I help?

Patient: I have some minor cough and a headache.

Nurse: When did this start?

Patient: I started coughing on Monday and I have had the headache since yesterday.

Nurse: I see. Have you ever suffered from T.B. or maybe a family member?

Patient: Not me, but my wife once had it.

Nurse: Was she treated for it?

Patient: Yes.

Nurse: For how long?

Patient: Six months.

Nurse: Was the family checked to see if they have not contracted it?

Patient: Yes, I came here and I was checked.

Nurse: And they did not find anything?

Patient: Yes.

Nurse: Okay, I see. Can you just lift your shirt. I want to check your blood pressure...Okay now, come and lie down here. I want to check your chest... I want you to go up and have your X-rays taken and then come back here with them.

4. Male Patient (23-30 yrs)

Nurse: Hullo, how are you?

Patient: I am fine.

Nurse: How can I help you?

Patient: I took an X-ray and I was told to come back.

Nurse: You were told to come back today? And what did they say was wrong with your X-rays?

Patient: They said they cannot pick up what the problem is and told me to come back today.

Nurse: To make another one?

Patient: They did not explain it tome.

Nurse: Did they take your cough specimen?

Patient: They did.

Nurse: And you left it here?

Patient: Yes.

Nurse: Oh, I see, you have come back for those results then. How are you feeling, now after the pills you were given the last time?

Patient: I am much better. My chest only hurts when it is cold.

Nurse: Does it only hurt when it is cold? What about on other days?

Patient: No, it doesn't.

Nurse: Are you still coughing?

Patient: I am still coughing.

Nurse: Is it still the same, no difference at all?

Patient: There is a minor difference.

Nurse: After taking your medication, was there any difference?

Patient: Yes.

Nurse: Okay, do you still remember where it was, where you took your cough specimen? I want you to go there and ask the nurses to give your results and bring them back with you. Take your card with you.

5. Female Patient (17 yrs)

Nurse: How are you? How can I help you?

Patient: I have a cough.

Nurse: How long have you been coughing?

Patient: Four months.

Nurse: You have been coughing for four months and you have never been to the doctor or clinic? Have you been coughing non-stop since it started, or does it stop for a while?

Patient: Sometimes the cough goes away but comes back again.

Nurse: Have you ever had a problem with your chest, asthma perhaps?

Patient: No.

Nurse: And in your family, anyone with asthma?

Patient: No.

Nurse: Has anyone been treated for T.B. in your family?

Patient: No.

Nurse: Okay, are you the only one who has this cough in the family?

Patient: Yes.

Nurse: How old are you?

Patient: I am seventeen.

Nurse: Are you still in school?

Patient: Yes.

Nurse: Did you report to your teachers that you were coming to the clinic?

Patient: No, I am going to ask for a letter to take back to school.

Nurse: You said you have been sick for four months? Sometimes the cough goes away?

Patient: Yes.

Nurse: Okay, come and lie here on the bed so we'll take a look.

(She then examines the patient.)

Nurse: Your stomach feels hard, are you pregnant?

Patient: No.

Nurse: When did you have your last period?

Patient: Last month.

Nurse: Do you get your periods regularly?

Patient: Yes.

Nurse: My, your stomach is really hard. Are you telling me the truth?

Patient: Yes.

Nurse: Well, then, you must naturally have a hard tummy. Your chest is clear though. It seems you just had a cold after all. I will give some cough mixture. Take a spoon three times a day. I do not have it here with me, so you will have to collect if from the dispensary. I trust you know where it is. The gentleman who gave you your card will write a letter for you to take back to school, okay?

Patient: Yes, thank you sister.

Rating: Judge 1 - Pre-Assessment

Nurse No: 5A

INDICATORS FOR SKILLS FOR COMPREHENSIVE CARE

The following ratings apply:

1 = absent
2 = poor
3 = adequate
4 = good

Relationship skills

	1	2	3	4
accurate empathy		X		
non-possessive warmth		X		
genuineness			X	

Microcounselling skills

	1	2	3	4
open questioning	X			
use of minimal encouragers	X			
noting and reflecting feelings	X			
paraphrasing/ summarizing	X			

Problem identification

	1	2	3	4
Inquire about associated illness problems	X			
Understanding the client's explanatory model of illness	X			
Reaching a common understanding of the problem	X			
Biopsychosocial -cultural formulation of the problem	X			

Problem management

	1	2	3	4
Patient participation in the generation of solutions	X			
Consensus on appropriate intervention	X			
Empowering patients to act on these interventions	X			

Rating: Judge 1 - Post-Assessment

Nurse No: 53

INDICATORS FOR SKILLS FOR COMPREHENSIVE CARE

The following ratings apply:

1 = absent
2 = poor
3 = adequate
4 = good

Relationship skills

	1	2	3	4
accurate empathy				X
non-possessive warmth				X
genuineness				X

Microcounselling skills

	1	2	3	4
open questioning			X	
use of minimal encouragers			X	
noting and reflecting feelings			X	
paraphrasing/ summarizing			X	

Problem identification

	1	2	3	4
Inquire about associated illness problems			X	
Understanding the client's explanatory model of illness			X	
Reaching a common understanding of the problem		X		
Biopsychosocial -cultural formulation of the problem		X		

Problem management

	1	2	3	4
Patient participation in the generation of solutions				X
Consensus on appropriate intervention			X	
Empowering patients to act on these interventions			X	

Rating: Judge 2 - Pre-Assessment

Nurse No: 5A

INDICATORS FOR SKILLS FOR COMPREHENSIVE CARE

The following ratings apply:

1 = absent
2 = poor
3 = adequate
4 = good

Relationship skills

	1	2	3	4
accurate empathy			✓	
non-possessive warmth			✓	
genuineness			✓	

Microcounselling skills

	1	2	3	4
open questioning	✓			
use of minimal encouragers	✓			
noting and reflecting feelings	✓			
paraphrasing/ summarizing	✓			

Problem identification

	1	2	3	4
Inquire about associated illness problems	✓			
Understanding the client's explanatory model of illness	✓			
Reaching a common understanding of the problem	✓			
Biopsychosocial -cultural formulation of the problem	✓			

Problem management

	1	2	3	4
Patient participation in the generation of solutions	✓			
Consensus on appropriate intervention	✓			
Empowering patients to act on these interventions	✓			

Rating: Judge 2 - Post-Assessment

Nurse No: 58

INDICATORS FOR SKILLS FOR COMPREHENSIVE CARE

The following ratings apply:

1 = absent
2 = poor
3 = adequate
4 = good

Relationship skills

	1	2	3	4
accurate empathy			✓	
non-possessive warmth				✓
genuineness				✓

Microcounselling skills

	1	2	3	4
open questioning				✓
use of minimal encouragers			✓	
noting and reflecting feelings			✓	
paraphrasing/ summarizing			✓	

Problem identification

	1	2	3	4
Inquire about associated illness problems		✓		
Understanding the client's explanatory model of illness		✓		
Reaching a common understanding of the problem			✓	
Biopsychosocial -cultural formulation of the problem			✓	

Problem management

	1	2	3	4
Patient participation in the generation of solutions			✓	
Consensus on appropriate intervention			✓	
Empowering patients to act on these interventions			✓	

APPENDIX 3

INTERVIEW GUIDE FOR PRIMARY HEALTH CARE NURSES

1. Nurses' understanding of illness

2. Nurses' understanding of healing

3. Nurses' understanding of their role as healers

4. Nurses' understanding of the causes of illness

5. Nurses' understanding of mental health problems

6. Nurses' understanding of the relationship between mental health problems and physical illness

7. Nurses' understanding of how they actually treat illness and how they ideally should treat illness

8. Nurses' understanding of their role in relation to helping people with mental health problems

9. Nurses' perceptions of how the health system constrains them from providing comprehensive care

10. Nurses' perceptions on how the system should change in order to enable them to provide patients with comprehensive care

APPENDIX 4

INFORMED CONSENT FORM (NURSES)

My name is Inge Petersen and I am a lecturer at the University of Durban-Westville. I am collecting data for the evaluation for the reorientation and training programme on mental health care that you will be attending/have attended. I would like to interview you on your perceptions and understandings of ill-health as well as observe your consultations with a number of patients.

Your name will not be used and every effort will be made to protect the confidentiality of the information that is obtained. This information collected will be used for research purposes, i.e. research publications and reports. Furthermore, a research report on the findings of the study will be made available to you.

Do you agree to participate in this study?

Signature of the participant:

Date:

APPENDIX 5

INFORMED CONSENT FORM (PATIENT)

My name is Inge Petersen and I am a lecturer at the University of Durban-Westville. I am collecting information on the type of care that patients receive at primary health care clinics. I would like to observe and record your consultation with the nurse, as well as maybe interview you about how you experienced your visit to the clinic. I do not require your name and confidentiality is ensured. The information collected will be used for research purposes, i.e. research reports and publications.

Do you agree to participate in this study under these conditions.

Signature of participant

Date